University of Glamorgan

'Awareness of health needs of prisoners - a pilot study within three Welsh Prisons'

Maggie Bolger

Gavin Fairbairn

Laurence Moseley

Donna Mead

School of Care Sciences, University of Glamorgan, Pontypridd, CF37 1DL

ACKNOWLEDGEMENTS

This project was funded by the Wales Office for Research and Development (WORD) for Health and Social Care, and we are grateful to them for their support.

We are grateful for the support received from our advisory team, in particular Dr Iain Robbe, Bro Taf Health Authority and Prof. Malcolm Mason, Velindre NHS Trust.

Finally we would like to thank all the staff of the prison service who helped in various ways, both in those who contributed to the data collection and those who facilitated its collection. We would like to thank in particular Mr John May, Operational Manager for Wales, HM Prison Service and Dr Gerry Evans, Acting Director and Mr Graig Jones, Project Manager, WORD.

CONTENTS
General Sections

CONTENTS
Tables

CONTENTS
Appendix

INTRODUCTION AND BACKGROUND TO THE STUDY

The general health care of prisoners has been the focus of considerable debate in the last few years, with a number of authors suggesting that it often falls short of health care in the wider community. For example, Reed & Lyne (1997) who carried out a series of semi-structured inspections of health care in 10 of 19 prisons in England and Wales studied, concluded that though the care provided was variable, in many cases it was of 'low quality'.

Prisoners have greater medical needs than the general population, are generally less healthy (Smith 1999; BMA 1993), and many of them arrive in prison with no health records, no diagnosis, and having had little if any contact with health services over a considerable period. Aspects of prison life, including its sedentary nature as well as isolation may well exacerbate existing health problems experienced by prisoners and separation from loved ones. Given this, and the high level of health problems among inmates, it is important that the health care system in prisons is as responsive to their health needs as possible. It is also important that discipline officers as well as health care staff are as aware as they can be of the importance of attention to prisoners' health status.

The White Paper *Custody Care and Justice* (1991) identified certain groups of prisoners as having particular health needs; for example, it noted the special needs of drug and alcohol users, sexual offenders, and individuals with mental health problems. Although mental health and drug misuse present serious problems for prisons, prisoners also experience a wide range of other problems, which would be regarded as medical by both health care and discipline staff. For example, a national survey of the physical health of 992 prisoners, undertaken for OPCS (Office of Population Censuses and Surveys) found that 48% of prisoners reported having a long-standing illness or disability (Bridgwood and Malbon, 1995). As physical and mental health conditions present their own unique challenges, managing them both simultaneously and under one roof is inevitably problematic.

The Future Organisation of Prison Health Care (1999) found that health care was inconsistent in British prisons and drew attention to the considerable variations that exist in its organisation, quality and effectiveness, including links with NHS services. It also addressed issues relating to funding. Better health care was found to be provided by prisons which had good partnerships with local health providers. Smith (1999) accepts the view of the Chief Inspector of Prisons (1996) that the NHS should take over health care in prisons completely. One argument against this would be cost. Sim (1999) points out that the NHS is unlikely to take on an influx of new patients who are considered to be problematic and costly.

The daily prison population is in the region of 65,000 people, with 200,000 passing through the system each year (*The Future Organisation of Prison Health Care*, 1999). The cost of maintaining this population is in the region of £1.8 billion per annum. In an overall reducing prison budget, Reed & Lyne (1997) point out that health care is likely to suffer. But, of course, prisoners who have health needs are patients just as much as anyone else. What is at issue, is which compartment in the public purse should provide for their needs.

Smith (1999) argues that investment in prison health could help achieve the government's declared aim of reducing inequalities in health. Hughes (2000) concurs with this view, stating that although policy in relation to prisons may appear to be discrete from policy in relation to health, it is likely that they will impact on one another. The National Association for the Care and Resettlement of Offenders (NACRO) claim that the NHS and partner agencies should take seriously the possibility that commitment to

health could have a positive impact on reducing crime (NACRO, 2001). However, we are unaware of any research that substantiates that claim.

Prisoners have a right to receive the same level and quality of health care as is found elsewhere in the NHS (*Prison Health Standards*, 1991). The Human Rights Act confirms that during a period of imprisonment prisoners remain citizens (Prison Reform Trust 2001). The challenges that face prisons in providing health care are considerable, since the primary function of a prison relates to the custody of prisoners and the protection of the public. The health of its population, though important, is very much a contingent rather than a primary concern (Horner, 1999; Reed & Lyne, 1997; Willmott, 1997). Prisons are thus not ideal settings in which to care for the health of inmates. Nonetheless, as the BMA (1996) points out, prisoners' loss of liberty should not imply a loss of right to medical care of a proper ethical standard.

Fursland (1999) and the BMA (1993) draw attention to the fact that prison health staff often experience 'role conflict' between their responsibilities for providing care and their responsibilities for maintaining security. In relation to nursing, the United Kingdom Central Council (UKCC) concurs with this view, and recommends that clarification of the therapeutic and custodial roles of prison nurses should be undertaken to overcome the issue of role conflict (UKCC, 1999).

Burrows (1995) draws attention to the fact that since admission to prison is not based on diagnosis, prison health care staff have to be responsive to a diverse range of health needs in individual prisoners. Staff awareness of the health of prisoners will arguably be dependent on the investment in education and training undertaken by the prison service. Since discipline officers are involved in health care in a number of ways, including the facilitation of contact between inmates and health care staff, it is clear that they need to have at least basic awareness of a range of health problems, both physical and mental. However, it has been suggested that many discipline officers are lacking in such awareness, at least in the case of mental health. For example, Harrison *et al.* (2001) (cited by McMillan 2001) suggest that discipline officers exhibit the same conceptions, which they call 'misconceptions', about mental health issues as that of the general population.

It is pertinent to note the BMA (2001) Report *Prison Medicine: A crisis waiting to break.* This small but important report outlines the current state of prison health care, drawing particular attention to the special health care needs of the prison population, who are identified as amongst the most needy in the country. It pinpoints the scarcity of resources, both human and financial, within prison health care, and recommends that the Government should recognise the need for greater financial support for prison health services. It also draws attention to the need to enable prison doctors to engage in continuing professional development, and to allow them freedom in exercising their clinical judgement.

The Future Organisation of Prison Health Care (1999) recommended that a health needs analysis be conducted by each prison in the UK in order to identify the health needs of their prison population, and to inform the planning and delivery of their health care. As a result, such work is currently being undertaken in many prisons across the UK, often making use of a 'Toolkit' devised by Birmingham University (1999). This may well represent a major step in the development of prison health. However, it could be argued that no matter how aware prisons are at an institutional level, the day to day delivery of care must also depend upon the individual awareness of staff, including discipline officers, of the health needs of prisoners. It is such awareness that we set out to investigate in this study.

AIMS AND OBJECTIVES OF THE RESEARCH

The project aimed to investigate the awareness among prison staff of the health needs of prisoners and the ways in which illness is managed within the current prison health care system.

Objectives of the research

The project had a number of particular objectives, as specified in the original proposal.

- to determine the perceptions of prison staff about the health needs with particular emphasis on life threatening/life limiting illness and other significant conditions.
- to find out how prisoners' physical and mental health needs are assessed and managed within the current prison health system.
- to develop a methodology and design for the next stage of the UK wide study, of which this is the pilot.
- to make proposals that will further develop health needs assessment and care provision within the prison service.
- to allow the development of proposals concerning the education and preparation of prison staff in relation to developing health needs assessment and care.

METHODS USED

The project had three stages:

Stage 1: Literature review and informal discussions

A literature survey, and informal discussions with senior prison staff allowed us to develop our knowledge and understanding of the variety of ways in which prison health care is delivered. It also provided valuable information in constructing a draft interview schedule for use in Stage 2.

Stage 2: Exploratory Study

The exploratory study, conducted in a prison outside Wales, had two elements: exploratory interviews and a narrative workshop. Combined with the literature search, these underpinned the development of the interview schedule, narrative workshops and questionnaire used in Stage 3.

Stage 3: Main Study

In the planning stages of the project, the main study was envisaged as having two elements: interviews and narrative workshops with health care staff and discipline officers. However, following the exploratory study a questionnaire survey with discipline officers was introduced as a third element.

ETHICS

Ethical approval for the project was sought from the Home Office via the Department of Health/Prison Service Health Ethics Committee, which grants ethical approval for health care research conducted in UK prisons. The Committee's approval letter stated that signed consent forms would not be necessary. The process of obtaining ethical approval from the Home Office is a lengthy one. It set our timescale back by several months. Thus, any delays occurred before the research proper started.

Participants in interviews and narrative workshops were invited to participate by a letter (see Appendices 1 and 3) which assured them that research data would be anonymised and treated confidentially. These assurances were repeated at the beginning of sessions, when we also explained our reasons for wishing to record the sessions and obtained permission from interviewees/participants before doing so.

Respondents were invited by letter to complete the questionnaire (see Appendix 1). The letter assured them that their responses would be anonymised and treated confidentially and made clear that participation was voluntary. Completion of the questionnaire was taken as an indication of consent.

SETTINGS IN WHICH THE RESEARCH TOOK PLACE

In order to avoid contamination of the main study, work for the exploratory study was conducted in a prison outside Wales. The work for the main study was conducted in 3 prisons in Wales, none of which were high security ones. The pattern of health care provision varied from prison to prison.

SOME BACKGROUND CONSIDERATIONS

It is very easy to fall into the trap of thinking that health care in prisons is the same as health care of the kind which most citizens' experience, but taking place in a prison environment. It is not. For example, the living conditions are different and more crowded, making precautions against infectious disease more salient. The range of conditions that occur may be skewed compared to that which would be found in the general population.

Inmates are not a random sample of the population. Firstly, they are less healthy than that outside, which in itself increases the pressure on the prison health system. Secondly, it was reported that inmates often resort to deception to try to achieve their desires (See Appendix 2 page 7). That makes the problem for prison staff greater. Every health care encounter involves the staff in making a decision as to whether they believe the account given by the inmate. So staff have a greater burden than those outside in assessing the trustworthiness of the data which they receive.

Prison staff are not a single homogeneous body. In particular, there are two major groups who are directly relevant to this study: health care staff and discipline staff. In addition, there are different staff groups within health care (i.e. those who have a nursing qualification and those who do not). Health care staff may also have a custody as well as care remit (HMP/NHSE 1999). All these groups are different in their backgrounds, training, daily experience, attitudes, interests and approaches. Therefore, one cannot talk merely of prison staff. For the purposes of this study, we have distinguished between discipline officers (DO) and heath care staff (HC) only.

Communication is an important issue in health care everywhere. In prisons, it is important that we distinguish the direction of the communication. One needs to distinguish custody-health care communication as a separate phenomenon from health care-custody communication.

Finally, prisons do not operate in a vacuum. In the first place, they are subject to very stringent custody regulations. These may at times conflict with the equally stringent professional codes of health care staff. Secondly, they are affected by policy changes in other parts of the body politic. In particular, they are affected by changes in mental health policy, e.g. the move to care in the community and the consequent closing of some psychiatric hospitals.

STAGE 1: LITERATURE SURVEY AND INFORMAL DISCUSSIONS WITH SENIOR PRISON STAFF

Developing the methods

A thorough literature review allowed us to contextualise the study. Informal conversations with colleagues at a senior level in the prison service allowed us to gain useful knowledge about prison practice and procedures, and informed the development of the interview schedule for the exploratory interviews in Stage 2, and the selection of the focus for the narrative workshops in Stage 2 and 3. Along with the results of the exploratory interviews and narrative workshops, they also informed the construction of the questionnaire later used in Stage 3. Finally, we linked with a local public health department who were undertaking a health needs assessment of prisoners. This needs assessment is still going on; when it is completed, it will offer opportunities to compare views of prison staff about, for example, the incidence and importance of a range of health conditions, against freshly collected information about their actual incidence.

A senior member of the psychology or health department purposively selected participants for the interviews and narrative workshops from volunteers, to represent the range of types and grades of staff.

All workshops and interviews were recorded, to allow us to capture participants' own words.

STAGE 2: EXPLORATORY STUDY - INTERVIEWS AND NARRATIVE WORKSHOPS AT A PRISON OUTSIDE WALES.

To avoid contamination methods for use in the main study were piloted in semi-structured exploratory interviews, and an exploratory narrative workshop at a prison outside Wales. At this stage, we were particularly keen to harvest the views and experiences of a variety of staff.

The prison in which we conducted the exploratory study was selected (with the help of the Manager for Prisons in Wales) because the range of prisoners for which it catered was similar to that catered for by two of the prisons in the main study. Following this exploratory work, we refined the methods we had planned to use in Stage 3.

Although this aspect of the project was in a sense a 'pilot' for a pilot study, it produced data which, together with data from the main study, supports the idea that what we have found in Welsh prisons may reflect the situation across the UK. For this reason, our report of this exploratory work is more detailed than it might otherwise have been. We have also supplied a detailed report of the results of the narrative workshop in Appendix 2.

i. Exploratory interviews

Interviews were held with 6 staff employed at the prison (see Appendix 3 for interview schedule). Those we interviewed included staff from the following groups: discipline officers, pharmacy, nursing, management (governor grades), and psychology. Interviews took approximately 30 minutes.

Focus of the interviews

Through the interviews, we sought to gain some understanding of the level of knowledge, understanding, and awareness that prison staff have of the health of prisoners. In particular we were interested to know how they would respond to situations in which they became aware of a range of presenting symptoms displayed by prisoners.

- Whether health screening is routinely undertaken on prisoners coming into prison and if so, what such screening entails.

- The extent to which information regarding prisoners' health is shared amongst prison staff.

Results of the exploratory interviews

Do prisoners routinely undergo any health screening?

All interviewees responded that prisoners are screened on reception. Screening focuses around a set of structured questions regarding physical health, mental health, previous hospital admissions etc.

Is information relating to a prisoner's health ever shared among staff?

In response to this question most interviewees answered negatively. It seemed that information about individual inmates is rarely shared with non-health care staff. Typical responses included:

> *"...the inmate medical record is a confidential document and that is not accessible to non health care staff."* (DO)

Things are different for health care staff, who receive information in the course of their everyday work. They are also different in the special situation of prisoners thought to be at risk of suicide or self harm, which is the issue in relation to which information is most likely to reach the discipline officers, usually in the form of '20/52 report', the central provision of the suicide prevention system in prisons. By contrast, there were no comments to indicate that information was shared with officers in cases where an individual prisoner might constitute a risk to other prisoners or to staff. Discipline officers expressed some concern that they were not always given information about individual prisoners who might constitute a risk to others, (e.g. infection).

Presenting symptoms

We invited interviewees to tell us how they would respond to situations in which they became aware of a range of presenting symptoms, for example, the prisoner who is complaining of a loss of appetite, or who is experiencing breathlessness. In such cases, some interviewees would suggest action, for example:

"I would possibly be worried and recommend that they see a nurse that day" (DO)

However, most interviewees were only able to interpret symptoms when clustered and presented to them in a particular order that indicated that something could be seriously wrong. For example, when we grouped together 'pale grey skin', 'chest pain', and 'breathlessness', most said that they would urgently refer the prison to health care and two were able to suggest that this might be indicative of a heart attack

Interestingly, some individual symptoms that we considered less significant, including 'difficulty in sleeping' and 'loss of appetite' were interpreted very differently by the prison staff, who considered them significant and indicative of mental health problems and/or typical of individuals participating in drug detox programmes.

Perceived differences between 'new' and 'old' officers

Some interviewees shared their perception that there was a difference between the attitude towards and opinions of prisoners, displayed by 'new' officers in the prison service and officers who had been in the service 15 years or more. The view was shared that the longer officers have been in the service the less sensitive or 'compassionate' they are likely to be. One newer officer said:

"I know they've done wrong (prisoners) but they're human beings and should be treated as such" (DO)

Officers who had been in the service longer were thus considered to be less interested in the prisoners as individuals and less caring. A couple of the interviewees stated that there was a 'tension' between the two groups of officers, with the longer serving officers seeking to influence the less experienced officers into their ways of thinking. The reasons for such differing attitudes were later investigated in the main study.

ii. Exploratory narrative workshop

A narrative workshop was held with 6 staff employed at the prison. This included staff from the following groups: discipline officers, the probation service, psychology and nursing

Process of the narrative workshop

The workshop lasted about one and a half hours and had two distinct phases:

a. Small groups: three researchers each worked with two of the six staff for approximately half an hour.

b. A plenary session: approximately one hour, with all workshop participants.

Focus of the exploratory narrative workshop

During the small groups, participants were invited to share stories about their experience of health care situations in prison and, in particular, about:

- The last health related incident /problem they dealt with and what happened.
- A health related incident or episode that had been particularly challenging, complex, difficult, interesting etc and to briefly write down details.

In addition, they were asked to reflect on and write a little about the health problems that they felt prisons were best equipped to address, and those that they believed prisons were least well equipped to address. After sharing their stories, participants wrote them down. The stories then fed into the plenary session, when participants were invited to begin by retelling them. The plenary session was recorded and transcribed.

Results of the exploratory narrative workshop

A wide range of issues were touched on in the plenary session. They may be grouped under three major themes:

- Drugs
- Communication between staff about health issues
- Environment, training, and resource issues

Drugs were the focus of a number of different issues. Many related to drug rehabilitation and centred round bullying for, and a trade in methadone. Concerns were expressed about the fact that work on drug abuse is wasted when inmates return to society,

'...within a week - less than that outside - they're back on drugs.' (HC)

Clearly, such problems were seen as difficult, time-consuming, and salient in the discipline officer survey, even though physical conditions were more frequently mentioned as occurring. No mention was made of physical conditions in the exploratory workshops (outside Wales) as compared to the narrative workshops in the main study, which are discussed later.

A number of issues revolved around communication – between different staff groups in prison, between prison staff and outsiders, and between staff and prisoners. Problems reported at the interface between officers and health care staff, include the impression on the part of some non-health care staff that they are not always considered to be credible sources of information about prisoners' health. Others related to the needs of officers to know more about prisoner's health, for example, whether a prisoner was diabetic, or might be found detoxing and more dramatically,

'...whether he's got AIDS or Hep or whatever just that he's got a communicable disease. As long as we know that, we know what precautions we have to take.' (DO)

Concerns were also expressed about the need for officers to be kept informed about potential suicide risks and about difficulties that they sometimes find in getting health staff to take action, which was perceived as sometimes causing control problems. Finally, problems arise because of the extent and nature of reporting mechanisms for incidents and concerns about sometimes having to record the same thing in several different ways for different purposes,

'...5 times I'm having to write the same sort of information.' (DO)

In general, the discipline officers provided a surveillance function for health care. Our data suggest that this function is performed well and consistently. Communication the other way round was said to be less satisfactory. Discipline officers frequently felt that they did not receive all the information which they wanted and needed.

"Its difficult especially when you're discharging somebody like from health care over to ordinary location and they say why was he over there with you but you cant really tell them. You know all you can say is basic things but nothing medical" (HC)

Many issues were raised about difficulties in providing for the health needs of prisoners, given resource constraints in terms of staffing, the prison environment, and other resources. Three particular issues concerned:

1. the conflict between health need and security in deciding where to locate prisoners with special needs and the most appropriate use of space in prison health care units.
2. the limitations of health care provision are a source of difficulty, including the, fact that staffing levels mean that when they are required.
3. concerns about emergency physical health situations (e.g. epilepsy, heart attacks diabetic coma),that echoed concerns in the main study. Non-emergency physical illnesses/ailments were not mentioned.

The particular requirements of prison nursing were raised, alongside concern about the use of agency nurses, who are sometimes ill-equipped for the general nursing role in prison and who may be ill prepared for the security issues that they face, *'...they think they can treat these lot as the same out there where it's a totally different environment.'* (DO). One possible solution was suggested, *'Each nurse that does come into a prison environment should be trained as a prison officer.'*(DO)

Some resource issues were of a very basic kind, including for example the need for basic equipment, *'...I mean if we've got spilled blood we should have bio hazards packs but we haven't got those either. We've got body spillage, body fluid spillage packs which for use by health care staff only...supposedly...all the normal safety stuff. Eye washes and things like that.'* (DO)

The exploratory study allowed us to gather fascinating information about a number of aspects of prison health care, and about the views and experiences of a range of staff. It also allowed us to make decisions about the best ways of approaching the main study, which comprised three mutually supportive methods of gathering data.

STAGE 3: MAIN STUDY - QUESTIONNAIRE SURVEY, INTERVIEWS AND NARRATIVE WORKSHOPS IN THREE WELSH PRISONS.

Interviews with health care staff

The interview schedule was refined following the exploratory study (see Appendix 3). The decision was also taken to focus interviews in the main study, on health care staff.

Narrative workshops with health care and other staff

Following the exploratory study we refined the process of the narrative workshops in two ways. First, each of the three main study workshops took the form of a plenary session. Secondly, at the beginning of each session participants were asked to write their stories down before telling and discussing them. This allowed the possibility of gathering narratives that were uninfluenced by discussions with colleagues. Narrative workshops in the main study, like those in the exploratory workshop, were conducted with mixed groups of prison staff.

Questionnaire survey of discipline officers

In the main study we introduced a questionnaire (Appendix 4) in order to survey the views and experiences of discipline officers who have 24 hour contact with prisoners and are therefore most likely to have the opportunity to become aware of particular health issues as they arise. The content of the questionnaire was broadly based upon the format of the exploratory interviews. The questions were designed not merely to make a superficial count of the answers, but to permit comparisons to be made between the answers to different questions. It was expected that this would lead to additional and reliable insights. It was also designed to avoid the danger of receiving merely socially desirable or fashionable responses. There were also a number of additions, and in place of the section on presenting symptoms, we instead clustered together symptoms which might be indicative of significant medical conditions such as a heart attack, in three clinical vignettes, asking respondents to outline how they would react, and why.

i. Interviews

Interviews were held with three health care staff at each of the prisons. The sample was provided to us, having been selected opportunistically by the head of health care. The range of staff interviewed included a doctor, a health care manager; registered general and mental health nurses, and health care officers[1]. In the analysis we have combined our responses from these groups into one category, called health care staff, and have compared them to one other combined group, discipline officers. No discipline staff were included in those requested because they were to be covered in the questionnaire survey. Interviews took approximately 30 minutes.

Focus of the interviews

We sought to ascertain the level of awareness, among health care staff of the health needs of prisoners, along with their views about a range of issues, including:

- The health screening of prisoners.
- Common health needs of prisoners.
- The prevalence of a range of health conditions.
- A typical day in health care.
- Training/education in relation to the health needs of prisoners (both that already undergone and perceived needs).

Results of the interviews

The interviews allowed us to gain a picture of the ways in which health care in the prisons was organised and delivered, and of the constraints and frustrations under which health care staff are working, including staffing pressures. One interviewee told us, *I've got 49/50 hours owed...you can't get back time owed.* (HC)

Another pointed out that:

> *"...planning for actual ongoing work such as health promotion is quite difficult because you're really struggling from day to day to meet the daily needs of the prison"* (HC)

[1] 'Health Care Officers' may be either, 'health care officers with no nursing qualification who have completed prison officer training plus three-to-six hours hospital officer training' or 'health care officers with a nursing qualification who have completed prison officer training'. (Wilmott and Foot 2001)

The central concern of prisons is with custody, rather than health care. However, there seem to be few aspects of prison life upon which health care does not impinge. One interviewee pointed out that:

> *"Health care permeates through the whole structure of the prison. Its not always appreciated."* (HC)

As this statement came from a group containing only health care staff, the phrase "It is not always appreciated" hints at a sense of being undervalued. The other quotations in this section support such an interpretation.

Health screening

Interviewees confirmed that all prisoners are screened on reception. The average time available per individual is 15 – 30 minutes, which some interviewees considered too little. For example, one said:

> *"Often there isn't a huge amount of time to do a lot of stuff. Apart from that you might have something like 17 people coming in, in one day."*(HC)

Some interviewees told us that prisoners may arrive in a shocked and stunned state, thus making it difficult to obtain good quality information about their state of health, for example,

> *"...when they first come in through reception...some of them are a bit traumatised. They are not always thinking straight."*(HC)

These intake screening records could provide valuable baseline data on the incidence and prevalence of various medical conditions if the data are reliably recorded. It will also be possible to compare the aggregation of such data (to indicate which conditions are present in the prison, and in what quantities) with the reports from the needs assessments which are currently underway. When those processes are complete we shall be able to report not only what the perceptions of prison staff were (which was our main task) but also whether those perceptions concur with a second measure.

Most common/problematic health needs

When we asked interviewees about the health needs that they encountered most frequently in prisoners, they listed the following:

- asthma
- diabetes
- substance misuse
- self harm
- chronic problems associated with old age, e.g. mobility
- mental health problems

The most difficult problems related to mental illness and substance misuse. Typical comments about the nature of such problems included:

> *"Very often before they appear in court, they will swallow all their pills, inject themselves, knowing that they are going to go down...by the time we get them they are in a very raw state. "* (HC)

> *"...unlike a medical hospital we cannot section or treat the patient as they come in."*(HC)

"Locking the door behind someone who is psychotic, distressed and disturbed is not good practice." (HC)

This is one of many examples in which what would be regarded as bad practice by a mental health specialist becomes a necessity when the officer handling an incident has to balance the needs of the individual psychotic against those of other inmates on the wing, and indeed of the good order of the prison.

How do health care staff become aware of health problems among prisoners?

Most interviewees stated that they would first become aware of the health needs of prisoners through prior notification from the courts and reception screening. However, during his sentence, custody staff, visitors, or cellmates sometimes raise concerns regarding an inmate's health:

(cellmates)..."they're the people that perhaps would notice more that anyone that there was a major problem"(HC)

"Inmates do report worries about their cellmates"(HC)

Quite often the prisoner himself would present to the health care staff either informally (request made on the landing) or via sick parade (which is held each day). Some interviewees acknowledged the part of discipline officers in alerting them (health care staff) to particular problems. For example, one said

"I find that the officers are very good at coming up with 'has so and so been up to see you today?'" (HC)

This view was supported by the questionnaire survey of discipline officers. In that survey, the officers had normally spotted that something was wrong with an inmate before the health care staff had reported the problem to them. There were 6 ways in which discipline officers found out that there was a problem with an inmate's health which were mentioned more frequently than 'informed by health care staff'. (See Table 6, page 28) These mainly arose from contact with the prisoner (e.g. noticing changes in their appearance or behaviour), although even being informed by a fellow officer was more frequently mentioned than being informed by health care staff.

Sharing of health information

Most interviewees responded negatively to questions about the extent to which information about health is shared with non-health care staff, because inmates' medical records are confidential. One pointed out the importance of:

"...medical in confidence...its our bond with the inmates" (HC)

However, non health care staff may be made aware of particular health needs in some circumstances, especially when it impinges upon custody matters, for example, if they are escorting the prisoner to hospital, or if the inmate needs to be excused from activities such as climbing ladders because he is epileptic. The kind of health care information most likely to reach discipline officers relates to self-harm. Issues may arise when there is a conflict between custody and care:

"There's a balance between retaining the dignity and confidentiality of the person's condition against the safety of having that person lead as normal a life as possible." (HC)

Officers can sometimes find out details about a prisoner's health by reading the prison record, which may detail some health information, for example,

"...a lot of court reports put down 'this insulin dependent diabetic'...so a lot of information does go out" (HC)

They can also become aware of health needs informally, for example, if the inmate tells them:

"Sometimes the inmate will talk to the officers about certain [health] issues..." (HC)

"We've had incidents where inmates have divulged information to the wing officers and its been used against them."(HC)

The results of the narrative workshops in the main study strongly support the idea that certain inmates often talk to discipline officers about their health. This was raised especially with reference to psychological and emotional matters, when some officers spoke as if they are a therapeutic resource for prisoners,

No discussion of communication would be complete without a consideration of the direction of the communication. It strongly appears to be the case that communication from discipline officers to health care staff is frequent, useful, and welcomed. The reciprocal concept (that discipline officers knew about prison health problems but kept that information to themselves was not mentioned.

However, the reverse process appeared to be more haphazard and infrequent. The health professional tenet of confidentiality led to many discipline officers not being fully informed about matters which would directly impinge on their day to day work and on their responsibilities towards prisoners other than the one who had a health problem. This appeared to be the case particularly when it came to infectious diseases, in which their wider responsibilities towards other inmates (and towards themselves and their colleagues) became more a matter of concern. However, some health care staff said that they learned to judge, which discipline officers could reliably be given such information, and would release it when they thought that it was in their patient's best interests.

A typical day in health care

A typical day for a member of prison health care staff starts at 7.30am. Routine activities begin with early morning medicine rounds; medicines have to be given out on time, as some inmates will be leaving for court at 8am *('Ensuring people have their medicine prior to going to court.'* HC) This is likely to be followed by pharmacy ordering; organising cover for staff absence; assisting in sick parade (*'...the main job is to try and balance the logistics of covering the sick parades in different parts of the prison'* HC); liasing with other departments and agencies, and conclude with the evening medicine round at around 4.30pm. Interviewees in all of the prisons commented on problems created by understaffing, and the constant challenges created by 'health versus custody' issues; such issues were common in the narrative workshops. Practical examples of this problem are given on 19-20* main report and page 36* (Appendix 4) under the heading 'Conflicts impinges on care".

Knowledge, education and training.

Nearly all of the interviewees stated that their knowledge of the health needs of prisoners comes from prior experience of working outside the prison, as well as experience gained whilst working in the prison service. Some had had basic awareness training, for example, in relation to self-harm issues, but all interviewees emphasised the need for ongoing

training and education in a wide variety of subjects. Typical responses to the question, 'Where does your knowledge of the health needs of prisoners come from?' included:

"...ours is a 'pick it up as you go' scenario (DO)

..."experience here, plus I worked in a large psychiatric hospital." (HC)

When we asked 'would you like any further training/education related to dealing with health conditions/problems in prisoners?' most interviewees welcomed any training on offer, in particular in relation to mental health issues. However, we were surprised to find that none spoke specifically in terms of wishing to have further training in relation to physical health needs of prisoners.

This is of interest, given our finding that discipline officers appear to define physical conditions as being to do with health (and therefore treatable by health interventions by health staff), whilst the mental conditions (particularly problems with drugs) appeared to be seen as something different, incomprehensible, and unpredictable (and thus less likely to be soluble by handing over to health specialists). The fact that none felt the need for training in physical conditions suggests that they are confident in managing these themselves, or are happy to hand these over to health care, whilst their desire for training in mental health suggests that (a) it impinges strongly on their day to day activities and (b) they see this as directly in their own domain, and not merely that of health care.

"...that a physical problem they might have and all you can do id advise them to see the doctor. And they say well 'that doesn't work. I've seen him' or ' No its useless its no point' and I was saying that if it was a mental health issue then I would feel happy to contact the doctor to talk about it. I'm not so happy to do that on physical issues that are not really my remit and I don't actually know that much about" (DO)

It should be noted, though, that a few staff saw themselves as having a pastoral role with some prisoners, and hoped that this informal supportive activity might help solve some mental health problems. Whether or not this would be effective requires further research.

Further data on the training issue arose in the narrative workshops. It will be seen that, discipline staff were frustrated at aspects of the service provided by health care staff. Clearly, some form of overlapping training might help to overcome these problems of perception. Most respondents would like to see better health care training for discipline staff. The discipline staff also wished the health care staff to have training, and in some cases experience, of the custodial functions of a prison.

ii. Narrative workshops

Narrative workshops were held with 6-8 staff employed at each of the prisons. The participants included a doctor, a chaplain, registered general and mental health nurses, health care officers and discipline officers.

The narrative workshop at each prison was planned to take one hour, and participants were keen to discuss experiences, and wished to go on even longer.

Process and focus of the narrative workshops in the Main Study

At the beginning of the workshop, participants were asked to complete the same task as in the exploratory study. Once again, the stories obtained were fed into the plenary session.

Results of the narrative workshops

A number of related concerns emerged from examination of the transcripts of narrative workshops. In the one pre-pilot workshops we identified 3 major themes. For the main study 3 workshops were held. Consequently more data and therefore more themes were obtained:

- Drugs issues
- Mental Health Issues
- The Prison/NHS interface
- Prisons as having the potential to make a difference
- Custody impinges on care
- Prison environment, training, and equipment
- Emotional and psychological support of prisoners and staff

Drugs Issues

As in the exploratory study, issues related to drugs featured strongly. In one workshop the importance of drugs in motivating crime was noted,

> *'People are not burglars any more they're druggies who burgle.'* (DO)

Major problems seemed to relate to the difficulties in preventing drugs being brought into the prisons,

> *"...it's more difficult to get that lump of cannabis which doesn't give many hits. So now what they have is crack cocaine and heroin which comes in under their tongue. "* (DO)

There are many other quotations about drugs (trade in them, security when administering drugs, rehabilitation, etc.) to be found in the appendices. In addition, the importance and salience of drug use by prisoners comes out clearly in the questionnaire survey. We asked how frequently they had to take action over specific named problems. While 39% of discipline officers never had to do so over drug detox. 46% of them said that they had to do so at least on a weekly basis.

Mental Health Issues

Issues relating to mental health were a major cause of frustration, for example, *'...when they won't consent to treatment and also where they're acutely mental ill.' (HC)* There is no recourse to compulsory treatment under the mental health legislation in prisons with the result that,

> *"...when they're particularly disordered and difficult to manage the only way you can deal with them is seclude them and invariably means they're locked up for 23 hrs a day "*(HC)

One problem that is seen to result from seclusion is that

> *'...invariably it makes their health deteriorate it makes the problems they've got worse.'* (HC)

One participant talked about,

> *...an incident ...where this guy was potentially dangerous and difficult to manage and was there for such a long period that he basically was almost unintelligible by the time we actually brought him in and started to care for him. He couldn't even speak properly anymore you know and he was horrendous to look at really.* (HC)

The potential for suicide and self-harm and its effects on security and custody was aired many times. The prison service has had a focused process for addressing suicide risk for many years and at least some participants seemed to think they handle this issue well.

The need to deal with severe mental health problems without recourse to the mental health legislation creates moral dilemmas. One participant talked of the possibility of using common law, but pointed out that this,

> *"...puts staff in very, very difficult situations of about...you know - do I not forcibly give treatment and see somebody...maybe the future for them...for their mental health being compromised or do I stick my neck out and do we give this under common law and the guidance is fairly vague* (HC)

One way of dealing with mental health problems in prisoners is to offer them help in developing coping mechanisms. This might be particularly important in prisoners who are 'at risk' of self harm:

> *"...if you put the input at an early stage in developing their coping strategies then that will reduce significant bit of risk... But again its resources* (DO)

Particular problems arise where inmates are depressed because of the situation in which they find themselves:

> *'Every human being is different aren't they and things have brought on the depression or things have perpetuated the depression and if you don't really do anything about that and you don't do anything about what their expectations are and what they're, what their sort of hopes are for the future then perhaps you can bung as much medication at them as you like but if you don't address any of the other issues..."* (HC)

If prisoners with mental health problems do not receive appropriate and prompt attention, their condition might deteriorate,

> *"....one of the worst things is that you know that their personality will start to disintegrate and their prognosis for the rest of their lives is going to be a lot poorer..."* (HC)

A reader who saw the above quotations but who did not know that they were produced in a prison environment would probably not realise what their source was. It is interesting that the issues raised, and the attitude taken, are so similar to those which would be found in community mental health teams. The government has recognised that there are too many cases where people who need secure care cannot be found a bed, remaining inappropriately placed in secure wards of prisons for far too long (NHSE 1999)

The Prison/NHS interface

Many participants perceived NHS facilities as uninterested in caring for their prisoners, because of the way in which inmates tend to be passed from one department to another, with no one taking responsibility for their care.

One example concerned a prisoner with a shoulder problem:

"...he's very poorly managed... we experienced great difficulties getting him seen.... Finally we had to actually.... one of the medical officers had to go down there with photographs of the man hand to the orthopaedic surgeon before one of them would be prepared to see him. " (HC)

Participants also believed that prisoners are viewed very negatively by many of their NHS colleagues:

"...in some cases there are judgements made because of the...type of prisoner that is there, that they are undesirable and that they are not worthy of the same standard of care and the sooner that they don't have to deal with them anymore the better...except...somebody needs to look after them ...we're not really able because of resources and the facilities that we have at our disposal" (HC)

Many participants believe that prisoners tend to be viewed by NHS staff as a threat. Discipline officers felt that this fear was exaggerated because as one participant argued,

'...what comes through the A & E on a Friday night is far more risky" (DO)

and a prisoner who needs to attend hospital will have a risk assessment and will rarely, it appears, attend hospital except in the presence of at least two officers.

However, there is some justification for the fear. A nurse working in the prison service is 18 times more likely than nurses working in the NHS to be assaulted (HMP 1998).

The problem of difficult prisoners was also highlighted by the following incident:

." ...we brought him back in the van out the back door of ITU in order to avoid the man's family. ...And that was more or less on the request of the staff in ITU because they were having difficulties handling him and his family"... **(HC)**

The same quotation illustrates what prison staff see as the relative lack of knowledge on the part of external NHS staff, about the nature of prison health care,

'I don't think that they quite understand the level of resources that are available here.'. (HC)

Another example of the lack of understanding of the limitations of prison health care, related to rehabilitation after stroke:

"...we've had patients go to..., that say are rehabilitating after a stroke.... I had to physically go down there myself in the car and explain to them and challenge their view of what the services we provide and say that you know, your criteria for discharge to prisons should be the same as that person's home." (HC)

The fact that prisons tend to have a 'hospital wing' may help to form the misconceptions of NHS staff:

"I think they know the services we provide cos they'll say like the hospital wing" (HC)

It is interesting that the participant who referred to the ITU incident above concluded with the words

"Now I mean that is a good example because you will never send someone home (directly from ITU) into the community" (HC)

Clearly, external NHS staff will rarely come across prisoners in the course of their normal working life. This means that their experience is too limited for the case management of rare events. It may be that there needs to be a specially nominated member of the prison health care staff to manage such cases.

Prison as having the potential to make a difference to a prisoner's health

A key issue that arose in the narrative workshops related to the potential that prisons have to make a difference, because effectively they have a 'captive audience' whose health they have the ability to change. One participant commented,

'*We save the lives of a lot of people by having them in prison,*'(DO) and another said that:

"I actually find that we're actually doing more for them once they become prisoners and we're stabilising them, we're giving them their medication." (HC)

For many prisoners entry to prison will be the first time there has been an opportunity to screen their health for a very long time:

"Like you know we health screen...the offending population which is quite good because they're likely to have the high risk of being unwell anyway before...But then with that information, you know we don't actually use it to its full potential. " (HC)

For persistent re-offenders entry to prison can be like a 'pit stop' where they go to be '...checked over and have a service'. One participant said:

"...we get a lot of these people back on their feet and they actually say to us themselves that they were looking forward to coming to prison so that we could deal with...you know the drug problem but also their diabetes." (HC)

Some prisoners were thought to organise their lives round regular visits:

'We had an individual, I mean he's dead now... No fixed abode. Would come in definitely every Christmas. I mean because he had no where to go; suffered with emphysema. "
(HC)

It is self evidently a good thing that individuals who are not in receipt of regular health care, should benefit from the health care prisons have to offer when they are inmates for a time. However, the fact that some such individuals seem to enter and leave prison via a 'revolving door' was viewed by participants as wasteful. For example,

"Time and time again...the same people are coming back and forth to prison. You've dealt with their health problems.... They go out and come back exactly the same problems again...It seems you're banging you're head against a brick wall sometimes". (HC)

Another problem concerns the possibility that having achieved some change in a prisoner's health status, he will lose the benefit when he leaves prison:

"Controlling their asthma whatever the case may be and that then all falls apart the moment they walk out the door because there's no follow up and they'll either walk straight back out and be prescribed benzo's even though you've just spent months getting them off or they got out there and become non compliant with treatment and thereby become ill again." (HC)

The general point is that since prisons have a captive audience they have the potential to make a real difference to prisoners' health. The fact that this benefit may be lost when the prisoner is discharged makes it easy to think that merely improving the NHS-prison

interface would remove the hiatus. However, the problem is larger than that, and involves the inmate's normal use (or non-use) of the NHS.

The role of discipline officers

A key group of staff, perceived as vital in achieving the potential of prisons to make a difference to the health of prisoners, were the discipline officers, since they have 24 hour contact with the prisoners. Indeed some issues were seen more as custody than as medical issues. As will be seen from the results of the survey, it is clear that such discipline officers are the main health surveillance agents, and most health problems of prisoners are picked up by them in the first place, e.g. in relation to self harm.

"My opinion...self harm is not a medical problem it's a prison officer problem that prison officers should be dealing with daily on the wings. You know that's our job to identify people who are depressed..." (DO)

Some officers talked about the way in which their role has changed and developed over the years. One told us that,

'We're more probation officers/psychiatric nurses now than we are prison officers.'(DO)

Education and training for discipline officers appears to have changed in recent years, and now encourages officers to adopt a more 'caring' approach. However, the full potential of officers to develop their caring role may never be realised because, as some of the officers stated,

'If a prison officer shows a bit of compassion and wants to care for a prisoner which at the end of the day is our job you're sort of seen as a soft touch. You know...he's not a proper prison officer " (DO)

Yeah but if any officer up there shows a bit of compassion, you know, he's often bullied and ridiculed..." (DO)

Clearly prisons can potentially make a large, although possibly temporary, difference to the health status of the sick people who pass through their doors. Some respondents went beyond this and suggested that health care in prisons could make a difference to the inmates' criminal behaviour. There is no evidence in the literature that this would be the case. Therefore, this assertion will require further research.

Custody impinges on care

Conflicts arise between the demands of custody and the demands of care are noted in many places in this report. In this section, we report varying views, which put flesh on that skeleton.

"After all we are a prison where custody and discipline are paramount. Which take over health care needs possibly. We've always been second fiddle." (HC)

A frequent perception of nursing staff in the workshops, was that their clinical judgement was being called into question:

"...the bottom line is they need to be seen in hospital, that's the decision we are not making a judgement on who is the most important because...basically it shouldn't be happening anyway but the danger is that you make a mistake because you aren't able to provide that sort of level of

insight and you make a mistake and somebody ends up seriously ill or dies as a result so you can't afford to…" (HC)

One nurse discussed her attempt to get a prisoner placed in a single cell,

People saw this inmate as sort of getting round the system. We agreed it as a health care team. That single cell application was beneficial this inmate. That, if he had a single cell his health care needs would be lessened. (HC)

This was an unusual request because single cells are generally reserved for prisoners who have earned the right to them. In this case,

the difficulty I had is standing up and saying this inmate's right and believe me its hard to…and I would back the guys up 100% but in this instant, this is why it do get me, is that I had to back this inmate and I found that daunting because…. we…become very isolated very, very quickly when we go against discipline. (HC)

The very strong emphasis that is placed on custody and security issues can lead to dangerous circumstances at times:

'There was a chappie who had dropped a big weight on his foot. 20kg in fact. Equally fractured. …custody issue…'Oh we haven't got the people to take him down to hospital' or 'We've got another one to go down as well…' so therefore…People really need now to go down without questioning it. A decision had been made to be treated immediately, seen in casualty.' Yet because they complain of staff shortages…these people are shipped to the wing and they have to wait. " (HC)

Even in emergency situations, custody seems to take place over the welfare of prisoners. As a result the minimum time to get an ambulance into prison is 15 mins:

If its 999 their minimum time, you know to get into because of security is 15 mins. [new speaker]…they can do it in 15 mins and that's at a push. But you know, that can be a problem in itself…what you're dealing with is an emergency. (HC)

Even though prison policy is to admit emergency ambulances immediately, in practice both discipline officers and health care staff said that for security reasons this goal is rarely met.

The UKCC (1999) recognised that nurses working in secure environments face significant and enduring role conflict in attempting to reconcile their responsibilities for therapeutic care and maintaining custody. This stemmed from the ambiguity of working with clients who are simultaneously patients and prisoners.

The concerns of discipline officers about the efficacy of health care staff (which was not personal, and may merely reflect resource constraints), and the concerns of health care staff about the constraints imposed by custody requirements, were widespread. More examples of comments about this issue will be found in Appendix 2.

Prison environment, training, and equipment

In the appendix, we give examples of problems under this heading. Here we concentrate purely on resources. Such issues underpinned many of the other themes that arose from the workshops, because without adequate resources not only can the best service not be provided, but much of what is provided will be wasted. This was obvious in discussions of the potential of prison health care to make a difference. Particular resource issues arose

in relation to a wide range of areas, including the provision of very basic equipment. One participant talked about a gentleman:

> *"…. He was incontinent to urine but he couldn't have a plastic mattress or a plastic underneath the sheets so I think he went through about 10 mattresses. He couldn't have them because it was too expensive. But the amount of mattresses he went and the amount of times I had to go over and show him the unofficial way of packing a bed so that more of the urine is absorbed in through sheets in preference to mattress and I found that really…Like something out of the dark ages."*
> (HC)

Another participant related a story about an inmate with a stoma:

> *"…with stoma care you need to have daily showers and you need privacy and all of the clean things and things. You know we couldn't just say to the officer 'make sure he has a shower everyday'…It's impractical. Its not that you don't want to offer him a shower everyday you can't there are too many who want one everyday."* (HC)

Resource issues also arose in relation to mental health, including the inability to monitor inmates with severe mental health problems adequately:

> *"….the reason why they're banged up for 23 hrs is that you've not got adequate resources to take risks because you know that you can take risks as long as you've got the staff available. I mean we had particular situations at the weekend where the prison…wanted to reduce us to one officer in the health care centre. One officer! You know for an in patient area of over 21 beds. With people who are mentally disordered, detox, physical health problems and that officer as well has got to respond to any medical emergency throughout the jail..."*
> (HC

Although many of the problems to which we draw attention in this report overall may seem to be due to staff attitudes, in fact underlying them there are, from the point of view of the staff, resource issues.

Emotional and psychological support of prisoners and staff

Many participants demonstrated real empathy with the lot of inmates, for example, in relation to the bereavements that prison can mean for them:

> *"I was talking to a man yesterday who I hadn't really spoken with before who told me that shortly after he came into prison, he'd written to his mother and she'd actually written to the prison authorities and said she'd didn't want to have any more contact with him. I can't imagine how that would strike me. I don't think any of us could but "*
> (DO)

> *"...we find that's a problem in itself because they're unable to go through the grieving process. I think a lot of our chaps that do actually go and have a loss. They're unable to say goodbye, to actually attend the funeral because they don't want to go handcuffed because they feel that's wrong despite the fact that they need to be. So they just can't put an end to actual sort of grief process. "*
> (DO)

Contact with incidents of the kind below can also be upsetting for officers who have to deal with them.

> *"…attended a suicide at a previous establishment a long, long time ago and it was a premeditated suicide this guy…it was obvious that he was going to carry it out to the end and I found that quite*

difficult to come to terms with. I mean the fact that we found him and he was there hanging really was out of our control." (DO)

It was evident from the extent to which participants talked about issues that upset them and disturbed them that they also need to have emotional support and opportunities for 'clinical' supervision and debriefing. Here we are not limiting the idea of supervision to the health care staff, but to discipline officers who clearly have an important role to play in the delivery of health care.

iii. Questionnaires (see Appendix 4)

A questionnaire was used to investigate the awareness among discipline officers of the health needs of prisoners; this gave the possibility of accessing the views and experience of a larger group than we could reach through interview and narrative methods. The choice of questions was informed both by the exploratory study and by the literature review. Initially it was based on the interview schedule for the main study, but this was refined through discussion with colleagues.

A random sample of 30 discipline officers from each prison was selected from staff lists supplied by prisons. Since this was a pilot, no attempt at further stratification was made.

Questionnaires and letters inviting members of the sample group to contribute to the project were distributed by the Senior Personnel Manager in each prison, who also collected completed questionnaires and forwarded them to us. Two weeks later a further letter (Appendix 1) and copy of the questionnaire were sent out to non-responders.

The response rate to the questionnaire was disappointingly low, with only 30 out of 90 (33%) individuals in the sample returning completed questionnaires; of these, two respondents returned blank questionnaires, saying that the nature of their work meant that they knew nothing about prisoners' health. We were disappointed and worried at having only a 33% response in the current study. However, the UKCC report on Nursing in Secure Environments (UKCC 1999), probably the largest study on the subject available, achieved response rates of 30-32% from prisons of various kinds (including the medium and low security ones which we studied in Wales). So, our results are no less and no more generalisable than those from that major report. It may well be the case that the non-response is potentially more informative than the actual answers given.

This was a pilot study. The representativeness of those who participated in the interviews and narrative workshops, and who responded to the survey clearly places a limit on the extent to which our findings may be generalised. However, the fact that there were the three data sources (survey, interviews, and narratives) means that when they support each other, the reported findings are strengthened.

Given the useful information provided by those who did respond, for future research we should take seriously the sensitivities of our likely sample members.

Results of the questionnaire survey

i. Do discipline officers receive information about individual prisoners' health? (Question 1a – 1f)

Respondents were asked to indicate whether they ever received information about a number of aspects of the health of individual prisoners: physical health problems; mental health problems; substance misuse; infectious diseases; medicines that the prisoner is taking, and special dietary needs. Only one discipline officer reported receiving information on all six

aspects of health, whilst 81% of the basic grade officers reported that they received information on 3 or fewer of the 6 problems listed.

Table 1: How many officers received information about a range of health conditions in individual prisoners?

Problem	**% of respondents receiving information**
Physical health problems	56
Special dietary needs	56
Substance misuse	56
Infectious diseases	44
Mental health problems	42
Medication	40

Rather surprisingly, most discipline officers did not receive information on many aspects of prisoners' health care. No clear pattern emerges. It is, however, a matter of concern that fewer than half said that they received information about infectious diseases or about medication, both of which are likely to be relevant to their day to day work. Although mental health problems are ones about which the officers are concerned, the information coming to them on this problem is of approximately the same order of magnitude as for other conditions. Overall, the picture is that half the discipline officers receive the information which they could reasonably use. This is further confirmatory evidence of the finding that communication from health care to discipline officers is not as complete (albeit for reasons of confidentiality) as it could be.

Where information was received about these aspects of health, we asked respondents who gave them this information.

Table 2: Sources of Information about various health problems in prisoners

Problems	**Sources of information (percentage distribution)**					
	Inmate	Other Prisoner	Prison officers	Health Care Staff	Multiple Sources	Other
Physical	14	0	29	14	43	0
Mental	9	0	18	18	55	0
Substance misuse	29	0	7	7	43	14
Infectious disease	27	0	36	18	9	9
Medicines	20	0	20	10	40	10
Dietary needs	43	0	7	7	21	21

It is clear that health care staff on their own are not a major source of information to discipline officers (although, like any of the sources, they may be included in the 'multiple sources' category). It is particularly surprising that health care scores much lower than other discipline officers (and than inmates themselves) as a source for information on infectious diseases. Similarly, with dietary needs and prescribed medicines, health care scores much lower than other discipline officers and inmates themselves. This may be because the health care staff place considerable emphasis on the concept of 'medical in confidence'. Whatever the reason, the perception of the discipline officers is that the health care staff are not a major source of information on inmates' health status.

ii. What are the most common health problems that officers encounter in prisoners? (Question 2)

Respondents were asked what in their experience, are the 3 *most common* health problems/conditions experienced by prisoners? They listed a wide range of health problems (21 distinct labels were used). We clustered these under 'physical health', 'mental health' and 'drug abuse'. In doing so, items that could have been coded in more than one way, were coded as follows:

- 'Self harm' and 'Imaginary illness' have been coded as 'mental problems'.
- 'Alcohol problems' have been coded with 'drug problems'.
- 'Age related problems' and 'lethargy' have been coded as 'physical problems'.

Table 3a: Perceived frequency of health Problems

Health Problem/condition	**Percentage of responses**
Physical health	59
Drug problems	21
Mental health	20

We next looked at the same data in its raw form, in order to prevent possible biases arising from discipline officers' vocabulary. Table 3b below provides an idea of the wide variety of problems which are likely to be encountered in the prison environment.

Table 3b: Perceived frequency of health problems

Problem	**No of responses**
Asthma	7
Headaches	6
Colds/flu	6
Sports injuries	3
Age related problems	3
Back problems	2
Heart problems	2
Epilepsy	2
Dental problems	2
Infectious diseases	2
General chest problems	1
Diabetes	1
Foot problems	1
Physical disabilities	1
Lethargy	1
Eye problems	1
Physical total	**41**
Mental health	11
Self - harm	2
Imaginary illness	1
Mental total	**14**
Alcohol problems	1
Drug problems	14
Drugs total	**15**

Not only does the above table give an idea of the range of conditions which officers perceive as arising; it also gives an idea of their mind set. Clearly, physical conditions bulk large in their minds, being three times as common as mental health problems, and three times as common as drug problems. As will be seen later, when it comes to the actions which officers have to take, and the training which they think that they require, the picture is quite different, with drugs and mental health topping the list. We think that there are (at least) 3 explanations for this apparent anomaly:

They know the names of many physical conditions, but of few mental or drug ones. They know that the treatments of, for example, foot and eye problems are different. They see physical conditions as being different from mental conditions. They appear to see physical conditions as health-related, whereas the mental and drug problems are seen as different in kind (but still a health problem). Some see them as behavioural, and most find them incomprehensible.

We cannot state which of these explanations is correct. However, the third one has other support from what officers said outside the questionnaire, for example

> *"to provide some training which is essential really if you're gonna work in an area like this, you know, Not in terms of mental health, in terms of responding to emergency."* (DO)

and we think that its wider validity should be tested in any further research.

iii. What are the most difficult health problems that officers encounter in prisoners? (Question 3)

The prevalence of conditions is one thing; the degree of difficulty which they pose in solving them is another. We asked specifically which were the most difficult problems to deal with. The pattern of answers was quite different from those offered to the previous question. The table below shows the distribution of difficulty, compared to the prevalence,

Table 4a: Perceived difficulty of dealing with types of health problem

	Percentage distributions	
	Commonest	**Most Difficult**
Physical health	59	23
Drug problems	21	32
Mental health	20	45

As will be recalled, physical conditions were thought to be highly prevalent, with 59% of the commonest conditions being said to be physical, with the other two main conditions being at the 20% level. However, when we asked which were the most difficult conditions to handle, the physical ones dropped to 23%, with substance abuse and mental health rising to 32% and 45% respectively Thus, although physical conditions are the commonest encountered, they are not the ones which officers find the most difficult. Table 5a below takes this process a stage further.

iv. How many prisoners do officers encounter in 6 months with a range of health problems? (Question 4)

We asked respondents to select from a given list roughly how many prisoners they encounter in a 6-month period with a range of medical conditions. This is an indirect way of assessing which health problems were salient in their consciousness (i.e. which problems were perceived as important and which were less so).

Table 4b: Estimated number of cases, of a range of health conditions observed by prison officers in 6 months

	Number estimated over 6-month period (% distribution)		
Medical condition	**None**	**1-3**	**4+**
Asthma	12	12	76
Heart Problems	24	28	48
Diabetes	12	56	32
Hepatitis	80	8	12
Cancer	44	48	8
TB	84	16	0
HIV/Aids	100	0	0

Clearly discipline officers come across, at least in their estimation, a substantial number of common health problems. One of the interesting findings is that the proportions having had no contact with the 3 infectious diseases in the list (TB, Hepatitis, and HIV/AIDS) were very high. This surprised us, as there were several comments about the problems which such diseases caused. It may, of course, simply be that they came across them, but had not been informed by health care (for reasons of medical confidence) of the condition which affected the inmate.

v. How often do officers have to take action in relation to a range of common conditions? (Question 5)

We asked respondents how frequently they had to take action in relation to prisoners who were suffering from a range of common conditions.

Table 5: Reported frequency of action in relation to a range of common conditions

	Reported frequency of action (percentage distribution)					
Condition	Never	2/3 times per year	Monthly	Weekly	Daily	At least weekly
Asthma	23	50	12	12	4	15
Heart Prob.	23	62	8	8	0	8
Self Harm	8	31	27	15	19	35
Drug detox	39	4	12	23	23	46
Mobility	8	58	27	4	4	8
Mental health	4	23	15	42	15	58

When it comes to taking action, the picture is quite different from when we ask about the prevalence of health problems. On this criterion, mental health, drug detox, and self harm rise to the top of the list, with the weekly (or more frequent) encountering of these problems

being reported by 58%, 46% and 35% of officers respectively. Of course, this does not represent the number of patients who are encountered in this way. One patient might be responsible for several actions in a week or a month. These numbers represent neither the prevalence nor the incidence of these conditions in a prison, but rather the perceived degree of burden which they place on discipline officers.

This picture reinforces and extends the picture given in Table 4a. It will be recalled that mental conditions were not the most commonly occurring problems, but they were the most difficult ones. We can now take this a stage further and show that they were also the conditions which were most likely to cause officers to take action.

Table 5a: Perceived frequency of the need action for dealing with types of health problem

Percentage distributions

	Commonest	**Most Difficult**	**Most Frequent ***
Physical health	59	23	23
Drug problems	21	32	46
Mental health	20	45	58

* Percentages sum to more than 100, because one officer can take action weekly or more frequently for more than one type of problem.

vi. How do officers first become aware of health issues in prisoners? (Question 6)

We asked respondents how they first become aware that a prisoner may have a health problem, and asked them to choose all that applied from a range of options.

Table 6: How do officers first become aware of health issues in prisoners? (percentage distribution, rank ordered)

Way of becoming aware	**Percentage**
Prisoner tells you	96
Notice change in appearance	92
Notice change in behaviour	85
Notice change in mood	81
You ask the prisoner	77
Fellow officer informs you	75
Informed by health care staff	62
Informed by relative/friend	31
Informed by 'listener'	23
Other	15

Officers become aware that a prisoner is unwell by the usual informal mechanisms which we all use in our day to day life – they notice something, or are told by the prisoner or a fellow discipline officer that there is a problem. The table above shows that these normal, everyday, non-structured ways of finding out that an inmate is unwell are the norm (75% or more of officers ranking them highly). Information from health care staff ranks well below this at 62%. This supports the general picture that information flow is more frequently from custody staff to health care staff rather than vice versa. Clearly, as one might expect, the discipline staff play a large role in health surveillance. They may not be well trained to undertake that task, but they seem to pick up many clues.

vii. How do officers act if they believe a prisoner is unwell? (Question 7)

We asked respondents how they would act if they believed a prisoner was unwell.

Table 7: Actions officers would take if they believe a prisoner is unwell (rank ordered)

Action	Percentage
Refer to nurse	92
Advise attendance at sick parade	85
Ask how prisoner is feeling	81
Report on shift handover	77
Ask cellmate to observe	69
Observe prisoner	65
Refer to doctor	58
Other	8

In this case, the picture is not so clear cut. In general, discipline officers will refer any suspected health conditions to the health care staff, either by direct referral to a nurse (and less frequently to the doctor) or by asking the inmate to attend the sick parade. However, they also undertake many actions which do not involve health care staff (talking to the inmate or his cellmate, passing information to other discipline staff at handover, or continuing observations oneself). Future research should investigate the nature of such informal mechanisms. This should include the extent to which discipline officers view passing information to other officers as an alternative to referring on and whether these informal mechanisms outweigh referrals to health care staff, and whether they take a workload off those staff, or merely delay ultimate referral, and perhaps permit deterioration in the inmate's condition.

viii. How do officers learn about the health needs of prisoners? (Question 8) This question was not aimed at the how they dealt with individual inmates, but rather how they built up their own knowledge base.

We were interested to find out whether officers learn about health and health needs through formal or informal mechanisms, and offered respondents a range of choices.

Table 8: How do officers learn about the health needs of prisoners? (% choosing option)

'On the job' experience	Information from prison officers	Information from health staff	Prison training programmes	Personal interest	News media	Other
92	71	63	46	38	17	4

The prison training programmes and information from health care staff clearly have and input to the knowledge base of discipline officers on prisoners' health needs and prison health care, being mentioned by 46% and 63% of discipline officers respectively. However, these are outweighed by information from other discipline officers and on the job experience, which score 71% and 92% respectively.

ix. How do officers act in relation to three particular sets of presenting symptoms? (Question 9: vignettes)

In order to gain some impression of how aware officers are of some common situations that might arise and how well prepared they are to deal with such situations, we asked them in Question 9, to respond to three vignettes.

Table 9a. George is quieter than usual this morning; he appears withdrawn and uncommunicative. His cellmate says that George hasn't slept well over the past few nights.

Actions suggested	**Percentage suggesting**
Ask after the prisoners' health	98
Inform healthcare	75
Refer to personal officer/listener/chaplain	54
Check for emotional problems/depression	35
Record/open 20/52	31
Monitor regularly	12
Suspect prisoner of taking drugs	4

Although the commonest reaction is an informal one (ask after prisoner's health), three quarters of the discipline officers would involve health care. Thus, we again have a picture of discipline officers saying that they initiate communication with health care.

Table 9b. You find Billy sitting in his cell. He looks pale, cold and clammy and is complaining of a dull, heavy feeling in his chest.

Actions suggested	**Percentage suggesting**
Refer to healthcare immediately	100
Suspect heart attack	42
Sit with the prisoner	27
Administer First Aid procedures	23

For this more immediate situation (suggestive of a heart condition), discipline officers are much more likely to inform health care. Indeed, all of them say that they would do so immediately. This is clearly a physical health problem. It may well be evidence that officers are well informed about symptoms of some serious conditions, (CPR is included in discipline officers' induction), and see those conditions as ones which are appropriate for the health care staff. We suspect that this is, by whatever definition one uses, perceived as a health problem and therefore the subject of a health referral.

Table 9c John is diabetic and is usually placid, but over the last half-hour, he has become aggressive and volatile, and he looks as though he will lash out at one of the prison officers soon.

Action	Percentage suggesting
Refer to healthcare immediately	88
Suspect that he needs insulin/ 'sugars' low	38
Offer sweet drinks/food	27
Ask after prisoner's health	27
Sit with the prisoner	19
Isolate for 'own' 'others' safety	15
Lie inmate down/calm down	11
Check for any other problems	4
Self-harm risk	4
Inform kitchen (possible dietary problems)	4

Although the results for this scenario are not as striking as in the previous one, the message is much the same. A substantial number of the discipline officers have some idea of what to do with an uncontrolled diabetic. Perhaps more importantly, most of them know that the condition is sufficiently serious that it should be referred to health care. Once again, the discipline officers are performing a surveillance function, and, if their claims are accurate, have no hesitation in referring the matter to health care, because they see it as clearly a health care problem.

There is an indication that discipline officers are able to exercise judgement over health matters. They draw distinctions. Quite properly, with 2 of the scenarios which manifest obvious physical health symptoms, a large majority would rapidly involve health care. It is interesting though that for the withdrawn and uncommunicative scenario, the commonest response is to talk to the prisoner. So, referring to health care is not an automatic action; officers exercise their judgement

Discussion of questionnaire results

In discussing the results, we will focus mainly on four areas of concern:

- How informed discipline officers are about individual prisoners' health.
- How aware discipline officers are about prisoner's health more generally, including picking up the warning signs of serious conditions
- The ways in which discipline officers act to meet prisoners' health needs.
- How difficult do officers find it to deal with the health problems of prisoners.

How informed are discipline officers about individual prisoners' health?

In general, responses to question 1, suggest that discipline officers do not seem to receive from health care staff a great deal of information about individual prisoners' health, or at any rate they do not report that they receive it (only 54% said they receive information about individual prisoners' physical health and only 43% and 42% said that they received such information in relation to infectious diseases and mental health respectively). This might be thought a matter of concern, particularly in relation to information about mental health problems and infectious diseases, since such knowledge (and its lack) may affect

aspects of their professional activities. They did, however, receive a great deal of information through informal mechanisms. One effect, they said, was that they had to treat all inmates as potential risks.

It could be argued that there are specific instances where the sharing of medical information could be beneficial to the inmate's well-being: for example, the unstable diabetic who becomes volatile on the wing because of hypoglycaemia. If discipline officers were made aware of his particular health needs, they would be more likely to be able to comprehend his mood swings, rather than merely treating him as being 'difficult'.

For two serious conditions in the vignettes, it was encouraging that a substantial number of discipline officers were able to suggest appropriate responses.

How aware are officers of the health needs of prisoners and how do they become aware of such needs?

Three questions, in particular, allowed us to investigate awareness of prisoners' health needs.

By asking, in question 2, what in respondents' experience, are the three most common health problems experienced by prisoners, we hoped to gain an impression not only of officers' subjective experience, but also of the range of awareness they have about health needs.

There were two contrasting pictures emerging. When asked about the incidence and prevalence of health-related conditions, they tended to talk about physical conditions. Indeed, in response to one question, they listed a large number of different named physical conditions. The accuracy of their perceptions will be evaluated when we are able to obtain data from the admission medical assessments and from the needs assessments which are currently underway. We have asked for such data, and we anticipate that it will be supplied to us for future analysis.

However, when asked about the amount of work engendered, and the problems and worries which arose with each sort of health condition, the picture changed entirely. In this context, the major factors were conditions which might be called loosely non-physical. These included self-harm, drug detox, and mental illness more generally. There is no doubt that these conditions were a cause of some anxiety to discipline officers. That concern is manifested also in their desire for further training in this area. Time and again, their responses read as though these conditions are not seen by most discipline officers as health ones. It is as though they can recognise heart conditions, asthma, or diabetes as known health conditions, for which there are known solutions, for which a referral to health care is an appropriate action. The more mental health and drug-related conditions seem to be incomprehensible and what should be done about them remains for them an unsolved problem.

Informal conversations indicated that many health care staff, and some discipline staff, felt that the closure of many long-stay mental institutions had meant that the only place for their former inmates to go was prison, and that they (the staff) had been left with a problem which was not really a custodial one. Typical comments include

"The care in the community became care in prison.' (DO)

'...when she (Mrs Thatcher) decided to have this care in the community experiment which has failed dismally, we picked up all the failures.' (DO)

Without fuller data, we cannot be sure that this perception is true, but it appears at first sight to have some merit.

In what ways do discipline officers act to meet prisoners' health needs?

If they believe that a prisoner is unwell, the vast majority of officers would involve the prison health care system at an early stage by referring him to the nurse, or by advising attendance at the sick parade (Table 7, page 28). Referral to the nurse is chosen by 92% of respondents, whilst the corresponding figure for the doctor is only 58%. Presumably, the officer is either making his or her own judgement of what would be an appropriate referral, or is putting the sick prisoner into the system and leaving the health care staff to decide as to appropriate onward referral. It was interesting to note the number of respondents who said that they would ask a cellmate to observe since none had said they ever received information about individual prisoners' health from other prisoners. Perhaps they viewed question 1 as relating only to 'reliable' sources and included other staff (formal source) and the prisoner himself (vested interest) as such sources.

65% of officers, believing that a prisoner may be unwell, say that one course of action they would take would be to observe the prisoner. This may suggest that they view caring for prisoners' welfare as part of their responsibility. It could equally well suggest that they wish to be persuaded (a) that the conditions is real (recall that they have reasonable doubts about the veracity of many of the inmates) and (b) that the condition is one which they feel is appropriate for referral to health care.

We have already shown that in terms of frequency of taking action (rather than of prevalence) mental health, drug detox, and self-harm were top of the list. However, being a discipline officer is not a single phenomenon. Thus, 46% of officers dealt with drug detox at least weekly, but 39% *never* did so. Clearly, the experience of different officers is very variable. For example, officers who worked predominantly on a wing that housed prisoners who were involved in drug detox programmes would naturally have more contact with such problems, and some officers might be inclined to view any disturbed or disturbing behaviour as evidence of mental illness, whether or not the individual in question had been formally diagnosed.

By contrast to their high degree of taking action with broadly mental health problems, officers seem to be much less involved with physical health problems. 61% reported that they have to take action only two to three times a year in relation to heart problems, and 58% and 50% said that they have to take action only two to three times a year in relation to mobility problems and asthma respectively. Clearly, physical health problems do not form a major element in their use of time.

Two things might explain this difference between the extent to which officers have to take action in relation to broadly mental health problems (including drug detox and self harm) and the extent to which they have to do so in relation to these three physical conditions. There is a suspicion that physical health and mental health problems differ in their predictability. A participant in the exploratory narrative workshop pointed out this distinction *'I think everything else is manageable because it is predictable but mental health is not predictable. So that makes it totally unmanageable.'* The distinction in essence is the nub of the problem facing the organisation of prison health.

In any future study, the measurement of frequency of taking action will need to be split into two parts (frequency and prevalence). The fact that 58% of officers reported taking action on mental health matters on a weekly or more frequent basis does not mean that 58% of prisoners had such problems. Indeed, it is unlikely but possible that one

prisoner may have been responsible for all that activity – firstly by being active on several days, secondly by involving many officers.

How difficult do officers find the health problems of prisoners to deal with?

Mental health problems and drug problems were not only the most common problems faced by officers but also the ones that some participants said that they found most difficult to deal with. This was not surprising. The reason might be that many of the physical problems they come across will require little involvement on their part, even when the problem is a significant one, whereas in a situation where a prisoner is disturbed and acting out - as might be the case both with prisoners undergoing drug detox and with prisoners who have mental health problems, officers are more likely to become involved, because of custody and discipline considerations.

Discussion of main findings

Each of the findings are discussed individually when they appear in the appropriate section (interviews, narratives, or questionnaire survey). Here we draw attention to some themes which either appear in more than one section, or which we think are salient.

The interview schedule provided a structured opportunity for staff to reflect on their practice. Most interviewees considered that access to health care in prisons was good, and better than that for the wider population. We were told that on entry to prison a prisoner must, legally, be seen by a doctor within 24 hours, both to allow health checks to be undertaken. In addition, an inmate who makes a request to see a doctor would receive medical attention, within 12 to 48 hours. This compares favourably with the length of time that many members of the general public can expect to wait before they can have a consultation with a GP. However, within the prisons, further action once an inmate has been seen by a member of the health care staff, will take longer, and this is both a cause of frustration for staff and can delay timely treatment.

Many staff in the workshops commented on the difficulties of managing inmates with mental health, drug, or self-harm problems, particularly those who presented with challenging behaviours. This view was echoed in the survey. Often the only way to manage them safely, given the security considerations that impinge upon health, seems to be through the use of seclusion. However, this carries with it the risk of a continuing deterioration in mental health, leading to the likelihood of poorer prognosis in the longer term.

The perception of health and custody staff alike was generally that prisons had became a *'dumping ground'* for individuals with severe mental illness. Several interviewees commented that since the advent of 'care in the community', prisons had become the new psychiatric hospitals, although they are neither resourced nor skilled for the problems that they are facing on a day to day basis. Again, this concurred strongly with views shared in the narrative workshops.

For participants in the narrative workshops, this was the first time that many of them had had an opportunity to discuss and air health issues with colleagues. The workshops gave rise to discussions that mirrored those in clinical supervision in the NHS, where staff can share stories related to critical (and sometimes harrowing) events in a constructive and supportive atmosphere. During these workshops, the researchers noticed that barriers seemed to dissipate between the various staff groups, perhaps leading to a greater appreciation of each other's respective roles.

Another cluster of significant issues arose in relation to communication. Here the perceived lack, of communication between the prison and external NHS agencies was particularly noticeable. It was claimed repeatedly that NHS staff want to minimise their contact with prisoners, for example, that casualty staff do not like having prisoners attending A & E units.

Another important communication issue arises from the dissatisfaction (whatever the reasons for it) expressed by discipline staff with health care staff. This is that communication can be in two directions: **from** discipline officers, and **to** discipline officers. The former was not apparently seen as a problem. Most of the concerns raised were in the latter direction.

All three methods of data collection used in the study gave us an indication that staff are aware of a wide range of health issues. By and large the close surveillance function which the discipline officers perform and the actions which they take suggests that for physical conditions, they are fairly well informed and will with confidence refer inmates onward to health care staff. However, for conditions such as mental health, self harm/suicide and drug related issues they are less confident, although they would like to have solutions, presumably because these are the problems that impinge upon custody matters most.

Many participants in the narrative and interview parts of the study commented on the considerable potential that prisons have in relation to tackling the health needs and concerns of individuals in prison, especially since in many cases they have not been in receipt of regular health care before entry.

Conclusions

This was a pilot study, conducted in order to develop methods and approaches for a larger scale study about the awareness among prison staff of the health needs of prisoners. It is timely, both because of the interest created by the recent BMA report *Prison Medicine: A crisis waiting to break* (2001) and because of the needs assessment that is currently underway in many British prisons. We wish to draw attention to several overarching themes.

1. The dramatic differences in knowledge and confidence of officers between the physical and the mental aspects of the condition of inmates are central to any consideration of the future. The impression was given that some, but not all, physical conditions were well understood by custodial staff. The mental and drug-related conditions were a major matter of concern to all groups, and the impression emerged that no obvious solution in the prison environment was available [2].

2. The perceived lack of communication from health care staff to discipline officers (but not vice versa) will also need to be the subject of attention. Although 'medical in confidence' is usually respected, it does cause problems, and pragmatic workarounds are sometimes found.

[2] We are encouraged that since this study was completed, several sources of evidence have served to reinforce this main finding. These include the response of prison staff at a seminar to discuss the research, and the publication of Department of Health, HM Prison, National Assembly for Wales (2001) *Changing the Outlook: A strategy for developing and modernising mental health services in prisons.* NHSE, London.

3. It was clear that for discipline officers in particular, many prisoners pose special problems, which are relevant to handling their health care. In particular, the fact that the veracity of prisoners is often in question, especially when they are involved in drugs. Not being able to trust a patient's word makes rational health care very difficult. Research into prison health care is likely to be unproductive unless the special nature of the population is taken into account.

4. There is unease evident in many of the comments made by discipline officers about health care provision. Many, not all, of the negative comments on this issue could well arise from the under-funding of prison health. However, such unease comes through frequently, and needs to be tackled if the discipline and health care staff are to work as a single team.

5. Our respondents believed that changes in mental health policy had seriously impinged on the problems which they faced, and that many of the current inmates are wrongly placed in prison.

6. In all, the picture is one of prison staff trying to do a good job within severe constraints which are beyond their power to control.

7. The last thing that is likely to solve the problem is simplistic suggestions based upon assumptions rather than on solid research.

Further research

The study has allowed us to identify a number of ways in which we can further refine our methods before embarking on a larger scale study and has also suggested avenues for more detailed investigation. For example, we intend in future research to do the following.

1. To fill in the background to the study by obtaining recorded data from the intake medical assessments of prisoners, and from the ongoing health needs assessments.

2. To investigate, if possible, how the veracity of inmates, or the officers' perceptions of it, affect decision-making at both the diagnostic and treatment stages

3. To study in a formal way how frequently officers obtain information about prisoners' health via their prison records.

4. To investigate how often officers are volunteered health information by prisoners in cases where health matters may impinge upon custody (e.g. prisoners with diabetes), and how often such information is not volunteered.

5. To investigate the flow of information in prisons taking into account the direction of the communication. Given the tension between the needs of day to day running of the prison and the confidentiality rightly espoused by health care staff, it is difficult to see how this tension can be overcome. Its presence should, however, be noted and investigated in any future research on this topic.

6. To investigate the ways in which individual staff are using the term 'mental health problems'; doing so might help to us to understand the large discrepancies between officer's estimates of the extent to which they are involved in dealing with such problems. This will require psychometric skills.

7. To locate studies which may suggest more effective ways of handling the behavioural problems which are currently causing such difficulties among all staff.

8. To undertake studies which have a more strongly empirical approach than has been common in the past. The major UKCC report (UKCC 1999) states, after a review of over 680 studies that previous research is generally derived from clinical anecdotes and concentrates on discussion rather than the presentation of empirical data and that to date it has not produced "an evidence base that could be applied to enhance practice" (pages 75-76). It is hardly surprising that there is so much anecdote, opinion, and varying perceptions when there is little firm evidence.

Objectives of the Research a reprise

- to determine the perceptions of prison staff about the health needs with particular emphasis on life threatening/life limiting illness and other significant conditions.

Respondents provided answers which revealed their perceptions of what constituted 'health needs'.

Discipline officers appear to draw a distinction between (a) clearly physical problems, which they feel fairly well informed about, and which they see as appropriate for intervention by health care staff, and for which they believe there are well-attested solutions and (b) mental health problems (which are not defined in detail), drug problems, and self-harm, which they do not see so clearly as being health problems, for which they do not see as having well-attested solutions, for which they want more training, and for which they would involve health care staff, in the hope that some solution can be found.

- to find out how prisoners' physical and mental health needs are assessed and managed within the current prison health system.

The exploratory study allowed us to gather fascinating information about a number of aspects of prison health care, and about the views and experiences of a range of staff. It also allowed us to make decisions about the best ways of approaching the main study, which comprised three mutually supportive methods of gathering data:

- to develop a methodology and design for the next stage of the large-scale study, of which this is the pilot. This larger sample will include prisons across the UK.

We have learned a great deal about the problems of gaining access, co-operation, and ethical approval for research in the prison environment. We would expect access, recruitment, and response to be improved by what we have learned. In any further studies, we would wish to draw a distinction between activity and prevalence. It would be easy to fall into the trap of thinking that high activity means high prevalence. We would wish to test whether that was the case, or whether high activity is caused by a few inmates who are seen many times and by many different staff.

- to make proposals that will further develop health needs assessment and care provision within the prison service.

Once we have been furnished with the results of the currently ongoing assessments, we shall be in a position to compare them with the results of intake health assessment, and with the perceptions of staff which we have obtained. At that point, we shall be in a position to make proposals.

- to allow the development of proposals concerning the education and preparation of prison staff in relation to developing health needs assessment and care.

We found that prison staff reported that mental health problems of inmates took up large amounts of their time, and were difficult to deal with. If law-breakers with mental health problems continue to be dealt with in prisons (and it has been recognised that this may not be an optimal solution) then two needs for training become apparent. Discipline staff need, and wish to have, training in mental health issues. Prison health care staff need training in the custodial aspects of the service.

Overall, caring for prisoners' health needs in prison is not easy, largely because of the conflicts between the ethos of care and that of custody. We heard of many examples in which treatment was delayed because of constraints placed by the custody regime. Thought needs to be given to ways in which security could be organised (but not compromised), especially to deal with physical health emergencies. For mental health, the impact of acute incidents on the smooth running of the prison is even greater. Earlier referral to appropriate treatment agencies outside the prison (or the provision of resources within the prison specifically for this purpose) needs to be considered.

No one has an answer to the problem. One is unlikely to be forthcoming until those who commission research consciously ask for research designs which will help us to replace perception and opinion with empirically sound evidence.

REFERENCES

Bridgwood, A. and Malbon, G. (1995) *Survey of the Physical Health of Prisoners, 1994*, Office of Population Censuses and Surveys, HMSO, London.

British Medical Association (1993) *Medical Ethics Today: Its Practice and Philosophy* BMJ Publishing Group UK.

British Medical Association (2001) Report *Prison Medicine: A crisis waiting to break*, BMA, London.

British Medical Association Medical Ethics Committee (1996) *Guidance for doctors providing medical care and treatment to those detained in prison*, BMA, London.

Burrows, R. (1995) 'Captive care: changes in prison nursing', *Nursing Standard*, Vol. 9, 22, 9-31.

Department of Health (1998) *Modern Mental Health Services: Safe, Sound and Supportive.* London. HMSO

Fursland, E. (1999) 'Inside Job' *Nursing Times*, Vol. 95 No 37, 24-26.

Her Majesty's Chief Inspector of Prisons (1996) *Patient or Prisoner? A New Strategy for Health Care in Prisons*, Home Office London.

HM Prison Service (1991) *Standing Order 13 – health care*, Home Office, London, (As amended, 1994).

HM Prisons News (2001) *Funding Boost for Prison Health Care,*

Home Office (1991) *Care, Custody and Justice: The Way Ahead for the Prison Service in England and Wales*, HMSO, London.

Horner, S. (1999) 'Introduction: Human values and health care in British Prisons, in Horner, S. and Stacey, M (eds.) *Incarceration: Human and Inhumane*, Nuffield Trust, London.

Hughes, R. A. (2000,) 'Health, place and British prisons', *Health and Place*, Vol 6, 57-62.

Joint Prison Service and the NHS Executive Working Group (1999) *The Future Organisation of Prison Health Care Report by the Joint Prison Service and The NHS Executive Working Group*, NHSE, London.

McManus, J. (2001) *Better Health, lower Crime*: a briefing for the NHS and partner agencies, National Association for the Care and Resettlement of Offenders, London.

McMillan I (2001) *Researchers Find Prison Staff Ignorant of Mental health Issues: Report of the 6th European Mental Health Conference.* Mental Health Practice Vol. 4, No 7, 5

Prison Reform Trust, (2001) *A hard act to follow? Prisons and the human rights act*, www.penlex.org.uk/pages/prthumac.html; 11.04.01.

Reed, J. and Lyne, M. (1997) 'The quality of health care in prison: results of a year's programme of semi-structured inspections' *BMJ*, 315, p1420-1424.

Sim, J. (1999) 'Prison Health Care and the Lessons of History', in Horner, S. and Stacey, M (eds) *Incarceration: Human and Inhumane*, Nuffield Trust, London.

Smith, R. (1999) *Prisoners: an end to second class health care?* BMJ, April, 318, p954-955.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Nursing in Secure Environments* UKCC London.

University of Birmingham (1999) *Toolkit for Health Needs Assessment in Prisons.*

Wilmott, Y. and Foot, V. (2001) 'Healthcare in Prison' in Bryans, S. and Jones, R. (eds) *Prisons and the Prisoner*, HMSO, Norwich.

Willmott, Y. (1997) 'Prison nursing: the tension between custody and care, *British Journal of Nursing*, Vol. 6, No 6, 333-6.

Appendix One – Correspondence

i. Letter to participants in interviews and narrative workshops in the exploratory study

Dear Colleague,

The general health care of prisoners in the UK is currently under review. The Government has recommended that, in future, closer working relationships should be established between prisons and national health service providers, in order to cater for the health needs of the prison population. In order to plan and develop health care services prisons and health authorities will need to know more about the specific health needs of prisoners.

As a Senior Lecturer, with NHS experience, I am interested in finding out more about the health needs of prisoners. I am especially interested to learn more about what you consider to be the particular health needs of prisoners, your experience of managing such needs, and the ways in which these needs are currently addressed within the prison health care system. It is intended that this research will assist in the future provision of health care for prisoners in Wales. Copies of the final report will be available on request.

I would be grateful if you would allow me approximately 15 – 20 mins of your time to ask you some questions regarding the general health care of prisoners. You may also be invited to attend a workshop, with other colleagues, to share your experiences of caring for prisoners with particular health needs.

All the information that you give will be anonymised and treated confidentially during and after the study. Your participation in this research is voluntary.
If you have any queries regarding this research, please do not hesitate to contact me on 01443 483136 (direct line) or write to me at the above address.
Thank you.

Maggie Bolger
Senior Lecturer

ii. Letter to participants in interviews and narrative workshops in the main study.

Dear Colleague,

The general health care of prisoners in the UK is currently under review. The Government has recommended that, in future, closer working relationships should be established between prisons and national health service providers, in order to cater for the health needs of the prison population. In order to plan and develop health care services, prisons and health authorities will need to know more about the specific health needs of prisoners.

As a Senior Lecturer, with NHS experience, I am interested in finding out more about the health needs of prisoners. I am especially interested to learn more about what you consider to be the particular health needs of prisoners, your experience of managing such needs, and the ways in which these needs are currently addressed within the prison health care system. It is intended that this research will assist in the future provision of health care for prisoners in Wales. Copies of the final report will be available on request.

I would be grateful if you would allow me approximately 15 – 20 mins of your time to ask you some questions regarding the general health care of prisoners. You may also be invited to attend a workshop, with other colleagues, to share your experiences of caring for prisoners with particular health needs.

All the information that you give will be anonymised and treated confidentially during and after the study. Your participation in this research is voluntary.
If you have any queries regarding this research, please do not hesitate to contact me on 01443 483136 (direct line) or write to me at the above address.

Thank you.

Maggie Bolger
Senior Lecturer

iii. Letter for potential questionnaire respondents

Dear Colleague,

The general health care of prisoners in the UK is currently under review. The Government has recommended that, in future, closer working relationships should be established between prisons and national health service providers, in order to cater for the health needs of the prison population. In order to plan and develop health care services, prisons and health authorities will need to know more about the specific health needs of prisoners.

As a Senior Lecturer, with NHS experience, I am interested in finding out more about the health needs of prisoners. I am especially interested to learn more about what you consider to be the particular health needs of prisoners, your experience of managing such needs, and the ways in which these needs are currently addressed within the prison health care system. It is intended that this research will assist in the future provision of health care for prisoners in Wales. Copies of the final report will be available on request.

I would be very grateful if you could complete the attached questionnaire. All the information that you give will be anonymised and treated confidentially during and after the study. Your participation in this research is voluntary.

If you have any queries regarding this research, please do not hesitate to contact me on 01443 483136 (direct line) or write to me at the above address.

Thank you.

Maggie Bolger
Senior Lecturer

iv. Letter following up non-respondents to questionnaire.

4/4/01

Dear Colleague,

Re: Questionnaire about the awareness of health needs in prisoners

You will have received a questionnaire in relation to research we are undertaking for the Welsh Assembly and with the approval and support of the Home Office. By accessing the views of prison staff we hope to be able to make recommendations to both the Assembly and the Home Office about ways in which they can further develop the delivery of health care to prisoners. Hopefully, this will benefit staff and prisoners alike.

In order that we can represent your views and those of your colleagues in this important work, it is essential that the questionnaires we have circulated are completed and returned to us. I would therefore ask that you complete and return your questionnaire, by return of post, in the enclosed stamped addressed envelope. If in the meantime you have already done so, please accept my thanks.

With thanks for your help and co-operation.

Yours sincerely,

Maggie Bolger
Senior Lecturer

Copy to: Governor
Main prison contact

Appendix Two : Full report on exploratory narrative workshop

A wide range of issues were touched upon in the narrative workshop. They can be grouped under three major themes:

- Drugs
- Communication issues
- Prison environment, training, and equipment

It should be noted that, given the size of the study, what follows should not be regarded as a formal content analysis. It is rather an informed commentary, made by researchers who were present at the narrative workshops, and who have since read the recorded transcripts.

Drugs

Drugs were the focus of a number of different issues, which were grouped into the following sub-themes:

- Prison procedure for issue and administration of drugs
- Security in relation to control drugs like methadone.
- Trade in prescribed drugs (Methadone).
- Drug rehabilitation.
- Excessive numbers of drug offenders in prison.
- Work on drug habits in prison is lost when inmates go back outside again.
- Drug rehabilitation programmes, for example, CARAT [counselling, assessment, referral, advice and through care].

The administration of controlled drugs, such as methadone (used in drug detox programmes) can be costly both in manpower resources and time spent in controlled drug rounds across each of the individual prison wings:

> *If methadone is to be served...well it is served on the wing. It's signed for by the nurse. It has to be counter signed by another nurse as well. It can't be just one person that issues it out it has to be two people there.*
> (HC)

Some issues related to drug rehabilitation and the existence of a resultant trade in methadone, which may be redistributed from prisoners for whom it is prescribed:

> *In the community there's a market for spit. Its called spit methodone*
> (HC)

> *It's a common problem, inmates trying to smuggle medication out of the treatment hatch, or vomiting it afterwards just to sell it off.*
> (HC)

Part of the problem seems to be that prisoners who are involved in drug detox programmes are not kept separate from the mainstream of activity.

> *In order to keep prison drug free or any area drug free it needs to be away from the main environment. If you've got people on A wing, G wing, D- wing or wherever who are still taking drugs or who are under drug rehab treatment its not the right environment for them to be in. They've got to be separate. It the only way it will work* (HC)

Not all officers believed that the problems caused by drug detox programmes were justified:

> *There is no physical need for them to have those drugs. They're not going to die if they're not given it so why give it to them.*
> (DO)

One believed that it would be more helpful to take other measures:

> *The best thing to do is once they come in, don't give them anything. Even go cold turkey. You'd have to deal with the control problem because they're more agitated than usual but that's what we get paid to do.*
> (DO)

Another issue arising from the existence of drug detox programmes in prison, related to the possibility that inmates may be bullied for their methadone:

> *...bullied or beaten up because they're getting more methadone than Joe Bloggs down the landing. But at least you've got a contained one area where the methadone is being issued in one area...*
> (DO)

Such issues demonstrate the close relationship between the constraints of custody and health care provision, in relation to drug users. Another concern raised in relation to drugs concerned the awareness, among participants, that work done on drug habits in prison is most often lost when the inmates go back outside again. One participant said:

> *...even if you get someone in here and you deal with that, their drug treatment. They're still going back outside and there's not...I mean...there's still people that fall through the gap and within a week - less than that outside - they're back on drugs.*
> (HC)

Difficulties in arranging continuity of care for drug users were highlighted against with the gap that exists between prison health care and the outside world:

> *Through care system has developed over the last 12 month probably better than it has been in the last 10 years. But its still not perfect. There are still a lot of people outside the prison service that think we're a world apart and refuse to deal with it. And it's the people like the [name of town] drug project that are actually bridging that gap to a certain extent and making the prison more accessible to outside.*
> (HC)

These concerns about a lack of continuity in care for prisoners when they return to the outside world, echo concerns found in the main study in Welsh prisons, about the possibility that prisons could be a focus of useful work with individuals who have serious health problems, including drug addiction, if only after care and resources could be sorted out.

Communication issues

A number of issues of different kinds revolved around communication – between different staff groups in prison, between prison staff and outsiders, and between staff and prisoners. They were grouped together under the following sub-themes:

- Role responsibility/remit conflict for officers.
- Prisoner's view that doctor is useless; reluctance to contact doctors.

- Inmates complaining about colleagues during therapeutic sessions; therapists feeling unable to give them space to discuss it.
- Sorting out genuine from non-genuine problems.
- Officers perceiving that at times, like prisoners, they are not believed.
- Advocating for prisoners.
- Health care staff not responding to custody staff's concerns.
- Bureaucracy, eg in reporting incidents and concerns.
- Officers' difficulties in obtaining information.
- Obtaining information when 20/52 prisoners return to wing from health area.
- Officer's views of the inadequacies of health care staff.
- Conflict between staff groups.
- Possible solution to perceived inadequacy of nurses working in prison environment.

One issue for staff related to the conflict that can arise for them when prisoners seem dissatisfied with the health care they receive:

> *...you get it from a lot of people that say 'I've got problems but its pointless going to see the doctor about it*
> (HC)

> *...prisoners saying something to you during interview....that a physical problem they might have and all you can do is advise them to see the doctor. And they say well 'that doesn't work I've seen him' or 'No its useless its no point' and I was saying if it was a mental health issue then I would feel happy to contact the doctor talk to the doctor about it. I'm not so happy to do that on physical issues that are not really my remit and I don't actually know that much about.*
> (HC)

Diffidence was expressed about the problem of what to do when prisoners expressed such dissatisfaction with the health care they were receiving:

> *...you know you can't...you have to be very careful that you're not slagging off your colleagues. 'Cos that's not what we're here for and sometimes it just makes it quite difficult.*
> (HC)

Other problems arose in relation to the need to make decisions about when prisoners who complain of illness, are genuinely unwell:

> *...everybody's assumed to be non genuine and then it's only the people that kind of persist really and actually are not really well at all that kind of get through and are seen eventually.*
> (HC)

Concerns were expressed that health problems might be overlooked in the case of prisoners who were considered unreliable:

> *We had an inmate on Sunday. He requested to see four listeners[1] through the day and because he couldn't get what he wanted, he wanted more medication he made himself vomit. And by doing that he tore the lining of his stomach, which made blood go in his vomit. Now they took him up to hospital and the only thing the hospital could find wrong with him is constipation. So you don't know where...who to help really some of times. Because if he's got a genuine problem now you're gonna think 'Ah he's doing it again.'*
> (DO)

[1] A 'listener' is a prisoner who has been trained to listen to the concerns of fellow inmates.

There were indications that relationships between health and non-health staff could be damaged by the impression on the part of some non-health care staff that they are not always considered to be credible sources of information about prisoners' health. One described it as being as if:

Not quite....you know....not really knowing what we're talking about.
(DO)

Prison staff saw themselves as fulfilling a potential advocacy role for inmates:

It's always a case of advocating for them. It might be that you particularly want them to be seen. You want an opinion of like a Psychartrist or you want to discuss their medication with the doctor.
(HC)

Problems discussed also extended to the needs of non-health care staff for information on prisoners' health. The need for officers to have access to information about prisoner's state of health was raised several times, for example:

...what they should have is maybe...James, D wing is a Psychopath or...Smith A wing diabetic...so that people are aware.
(DO)

Jones - known drug user needs to be kept aware of - might be found detoxing might be found trying to screw medication of other people - might be found drug dealing. 'Cos the guy might come in and try and score. The guy might come in and try and detox for three or four days in his cell on his own and you need to know that sort of situation.
(DO)

I mean one thing we have to know, whether he's got AIDS or Hep or whatever just that he's got a communicable disease. As long as we know that, we know what precautions we have to take.
(DO)

There is no access to a prisoner's medical records
(DO)

That's all we need is just a brief information we've got to deal with. If we know we've got to deal with a diabetic...
(DO)

The need to be kept appraised in relation to prisoners considered to be at risk of suicide seemed particularly important and was raised by one officer, who talked of a situation in a previous prison where:

If we had somebody who was suicidal and was admitted to the hospital, they'd have a 20/52 open on them but the hospital staff would fill in, in the inmate medical record. So they might be in the hospital wing for a week, 2 weeks, 3 weeks and that whole chunk will be missing from their 20/52 'cos they wouldn't have filled that out.
(DO)

Discipline officers reported difficulties not only in accessing information about prisoners' health *('We don't get told when there are particular problems with a particular inmate.')* but in getting health staff to take action. For example, one said:

...anything that we feel there is a problem with a particular inmate. It gets passed on to health care but they don't react.... And some times it can be days.....weeks before anything is ever done

about it but that makes our job twice as hard because it then becomes a control problem not a medical problem.

Finally, particular problems with communication seem to arise because of the extent and nature of reporting mechanisms for incidents and concerns. For example,

I was also saying...if I go and see somebody and I want to pass my concerns onto the wing staff...to make sure that happens I have to fill in the page sixteen[2], probably the incident book as well and they might be on a 20/52[3]. They might have been referred by the hospital so I'll have to give a report back to the hospital and then write my notes up as well. Which is ...5 times I'm having to write the same sort of information
(DO)

Prison environment, training, and equipment

Many issues were raised about difficulties in providing for the health needs of prisoners, given the resource constraints. These constraints related to staffing, the limitations of the prison environment and to other resources. Issues were clustered into a number of sub-themes:

- Problems about where prisoners with mobility and other needs, are located.
- Need for health care presence more of the time.
- Worries about emergencies and lack of staff.
- Difficulty getting health care staff on to the wing.
- Agency nurses.
- Lack of support outside/lack of GP contact.

The part that thinking about security plays in making decisions about where to locate particular prisoners raises particular issues. For example one participant told us that:

...the whole aspect of where a prisoner goes and what sort of cell he's in and where he's located isn't really looked at. They're a body we've got a space, he goes in that space. We've got it to where it is and the staff cope with. It's a case of 'Oh well he's there now we'll leave him there'.
(HC)

Related to this, there was some discussion of the most appropriate use of space in prison health care units. For example, one participant said:

They can look at that and say 'OK well this particular guy can hardly walk'.... He's in a wheel chair whenever he went to visits or whatever he could manage to walk around the landing. Then they should have said right 'OK he's in with us now we'll locate him in the health care unit until we can decide what we've got to do with him.' That's the sort of person they should be looking at to locate in health care not these guys who decide they're not having medication, they're going to kick off, they're going to go there for the night.
(DO)

Choice of location for prisoners depends on custody decisions, eg, they might decide to keep all rule 45 prisoners[4] on the third floor, even if one of them is in a wheelchair.

---

[2] An individual file on a prisoner.
[3] A 20/52 is a record maintained in relation to a prisoner thought to be at risk of suicide.
[4] People who are segregated for their own protection, 'Vulnerable' prisoners.

Prisons are unlike other parts of society (other than the general health care system) in that health care facilities are available on the premises. However, attention was drawn to the fact it can be difficult to summon help quickly if needed:

We require health care presence and it invariably takes them quite a while to get over to right levels and landings or whatever.
(DO)

One particular concern related to the difficulties that officers face in the case of emergencies:

Well if you've got someone who has a diabetic coma or an epileptic fit or an assault even, a serious assault, it needs to deal with sooner rather than later and if health care are busy then they're very reluctant to send a member of staff over.
(DO)

...there is a difficulty if you have a prisoner that has a physical problem there is a difficulty in getting health care staff across. We...was it a couple we lost with heart attacks a couple of years back?'
(DO)

One officer expressed concern that the health care system might not be able to cope in the event of emergencies:

If it's a heart attack to someone's fell over then the response time will be different but I don't think they are geared up for...I mean if something major was to happen I don't think the health care centre would be geared up.`

Some discussion took place of problems that relate to the lack of understanding, on the part of some health care staff, of the constraints that security necessitates. For example, one officer said:

They don't know about coming into volatile situations like education where its enclosed, the same with the wings as well. Speaking to prisoners, not informing staff that their going to see prisoners? You get some of these nurses come in and you've basically got to tell them on the wing the security side of it.
And they've got their boxes full of treatments and whatever and they just wander on in. Well yeah...you know thanks a lot
(DO)

Such problems imply a need for additional training for nursing and other health care staff. One possible solution was suggested:

Each nurse that does come into a prison environment should be trained as a prison officer.
(DO)

Particular problems arise in the case of agency nurses:

...what you've got here is a load of agency stuff isn't it. Its not even the same nurses is it so....yeah I agree with you but You know what you've got here is people just coming in just as an agency.
(DO)

...they think they can treat these lot as the same out there where it's a totally different environment.

(DO)

Agency nurses come with extra problems both because of the lack of continuity and because they lack knowledge of the prison system. However, at times there are other, more particular problems. One participant observed that:

> *They recruited quite a few last year that were registered mental handicapped nurses...that were having to be taught to do injections because they haven't done them for so long.*
> (DO)

Issues relating to resources were also raised in relation to basic equipment for use by staff:

> *One I mean if we've got spilled blood we should have bio hazards packs but we haven't got those either. We've got body spillage, body fluid spillage packs which for use by health care staff only...supposedly...all the normal safety stuff. Eye washes and things like that.*
> (DO)

Appendix Three – Interview Schedule

ii. Interview schedule for exploratory interviews at a prison outside Wales.

Section 1:
Biographical Data (to be completed by the respondent):

Sex M/F (please circle) Age ... ...

Post Held ... ... Length of time in Post ... ...

Length of time in prison service ... ...

Brief description of post held ... ...
... ...
... ...
... ...
... ...
... ...

Brief details of prison service training/induction undertaken to date (if applicable)
... ...
... ...
... ...
... ...
... ...

Brief details of previous employment history prior to entering prison service (if applicable)
... ...
... ...
... ...
... ...

Section 2:
Prisoners Health (interviewer ask the respondent):

1. Do prisoners routinely undergo any health screening?
   (If yes, are they aware of why this is done and what it entails?)

2. What health conditions/problems do you come across, in prisoners, on a day-to-day basis?
   (If they answer only with reference to mental health problems, ask about what physical problems they encounter)

3. What particular health conditions/problems, in prisoners, cause you the most concern, or cause you the most work?
   (Ask them to tell you a bit more about these concerns)

4. How do you first become aware that a prisoner may have a particular health problem?
   (If they answer only with reference to mental health problems, ask about any physical problems they encounter)

5. If a prisoner complains to you of feeling unwell, what do you do?

6. Do relatives/friends/other inmates ever report concerns about an inmate's state of health?
   (If yes, what do you do?)

7. Is information relating to a prisoner's health ever shared amongst the prison staff?
   (If yes, what type and how is this information shared?)

8. If a prisoner requests to see a doctor or nurse, how do you respond?

9. Have you had any training/education in dealing with general and/or particular health issues in prisoners?

Section 3:
Common Signs &Symptoms (interviewer ask the respondent):

If a prisoner comes to you complaining of the following – what would be your response?

Breathlessness/difficulty breathing
High temperature/feeling hot
Bowel problems
Poor sleep/sleep disturbance
Chest Pain
Difficulty in mobilising
Numbness/tingling/stiffness sensation in limbs
Palpitations/rapid heart beat
Difficulty passing water
Loss of appetite
Skin irritation

If you observe the following in a prisoner - what would be your response?

Pacing
Self mutilating
Sweating profusely
Pale/grey skin colour
Withdrawn/isolated
Talking to themselves
Suspicious of others
Emotional
Vomiting
In pain

Section 4:
General comments (interviewer ask respondent):

Where does your knowledge of the health needs of prisoners come from?

Would you like any further training/education related to dealing with health conditions/problems in prisoners?
(If yes, what type?)

Do you have any other comments to make related to the health of prisoners?

iii. Interview schedule for interviews at three Welsh prisons.

Section 1:

Biographical Data :

Sex: Female ☐

Male ☐

Age:

Please tick relevant box

Under 25 ☐

26 – 35 ☐

36 - 45 ☐

46 – 55 ☐

56 and over ☐

Job title/grade: _____

Length of time in prison service:

Please tick relevant box

Less than 5 years ☐

6-10 years ☐

11-15 years ☐

16-25 years ☐

26+ years ☐

Which of the following have you had experience of prior to joining the prison service:

Please tick relevant box(es)

University ☐

NHS ☐

Community /Social Work ☐

Armed Forces ☐

Police ☐

Other please state: _____

Have you received any training/education related to the health of prisoners?

Please tick relevant box

Yes ☐

No ☐

If yes, please list all prison service induction/training undertaken related to prisoners' health:

_____

_____

_____

_____

_____

_____

Section 2:

Prisoners Health:

1. Do prisoners routinely undergo any health screening?
(If yes, are they aware of why this is done and what it entails?)

2. What are the 3 most common health conditions/problems that you come across, in prisoners?
(If they answer only with reference to mental health problems, ask about what physical problems they encounter)

3. What particular health conditions/problems, in prisoners, cause you the most concern, or cause you the most work?
(Ask them to tell you a bit more about these concerns)

4. How do you first become aware that a prisoner may have a particular health problem?
(If they answer only with reference to mental health problems, ask about any physical problems they encounter)

5. If a prisoner complains to you of feeling unwell, what do you do?
(What is the procedure?)

6. Do relatives/friends/other inmates ever report concerns about an inmate's state of health?
(If yes, what do you do?)

7. Is information relating to a prisoner's health ever shared amongst the prison staff?
(If yes, what type and how is this information shared?)

8. Describe a typical day for you?
(routines, medicine rounds etc)

9. Have you had any training/education in dealing with general and/or particular health issues in prisoners?
(If yes, do they feel adequately prepared to deal with such issues?)

Section 3:

Common Health Problems:

10. Roughly how many prisoners would you come across in an average six month period, with each of the following medical conditions?

Medical condition **Number of prisoners with condition (if none, please indicate)**

Diabetes _____

Asthma _____

HIV/Aids _____

Hepatitis _____

TB (Tuberculosis) _____

Cancers _____

Heart problems _____

11. On average, how often do you have to take action in relation to the following health conditions in prisoners?

Medical Condition	**Daily**	**Weekly**	**Monthly**	**2/3 times per yr**	**Never**
Asthma					
Heart Problems					
Self harm					
Drug Detox					
Mobility Problems					
Mental health Problems					

Section 4:

General comments:

12. Where does your knowledge of the health needs of prisoners come from?

13. Would you like any further training/education related to dealing with health conditions/problems in prisoners?
(If yes, what type?)

14. Do you have any other comments to make related to the health of prisoners?

Appendix Four - Questionnaires
iv. Questionnaire for Main Study.

PRISON HEALTH QUESTIONNAIRE – PLEASE COMPLETE ALL SECTIONS

Section A

Please indicate whether you ever receive information about the following aspects of individual prisoner's health (make sure you answer each of 1a – 1f).

1a. Physical health problems Yes ☐ No ☐

If you answered yes, who gives you this information?

_____

1b. Mental health problems: Yes ☐ No ☐

If you answered yes, who gives you this information?

_____

1c. Substance misuse: Yes ☐ No ☐

If you answered yes, who gives you this information?

_____

1d. Infectious disease: Yes ☐ No ☐

If you answered yes, who gives you this information?

_____

1e. Medicines that the prisoner is taking: Yes ☐ No ☐

If you answered yes, who gives you this information?

_____

1f. Special dietary needs: Yes ☐ No ☐

If you answered yes, who gives you this information?

_____

2. In your experience, what are the 3 *most common* health problems/conditions experienced by prisoners?

_____

_____

_____

_____

3. What health problems/conditions do you find are the *most difficult* to deal with/cause you the *most* problems?

_____

_____

_____

_____

4. Roughly how many prisoners would you come across in an average six month period, with each of the following medical conditions?

Medical condition	*Number of prisoners with condition (if none, please indicate)*
Diabetes	_____
Asthma	_____
HIV/Aids	_____
Hepatitis	_____
TB (Tuberculosis)	_____
Cancers	_____
Heart problems	_____

5. On average, how often do you have to take action in relation to the following health conditions in prisoners?

Medical Condition	Daily	Weekly	Monthly	2/3 times per yr	Never
Asthma					
Heart problems					
Self harm					
Drug detox					
Mobility problems					
Mental health problems					

6 How do you first become aware that a prisoner may have a particular health problem/condition?

Please tick all that apply

Prisoner, himself, tells you ☐

You ask after the prisoners' health ☐

Relation/friend informs you ☐

Prison 'listener' tells you ☐

You notice a change in prisoner's physical appearance i.e. Prisoner 'looks unwell' ☐

Informed by health care staff ☐

You notice a change in prisoner's behaviour ☐

Prison officer informs you ☐

You notice a change in the prisoner's mood ☐

Other (s) please state: _____

7. If you believe that a prisoner is unwell, what would you do?
Please tick all that apply

Observe the prisoner for a period of time ☐

Report that the prisoner is unwell on shift handover ☐

Refer to Prison Doctor ☐

Refer to Prison Nurse ☐

Ask the prisoner how he is feeling ☐

Ask prisoner's cellmate to observe ☐

Advise the prisoner to attend the next sick parade ☐

Other please state: _____

8. How do you learn about the health needs of prisoners?
Please tick all that apply

Prison service-training programmes ☐

Experience gained 'on the job' ☐

Information gained from other prison officers ☐

Information gained from health care staff ☐

Personal interest /read around subject ☐

News/media ☐

Other please state: _____

9. Please read the following situations and for each please say what you would most likely do and why.

a. George is quieter than usual this morning, he appears withdrawn and uncommunicative. His cellmate says that George hasn't slept well over the past few nights.

Briefly describe what would you do and why?

b. You find Billy sitting in his cell. He looks pale, cold and clammy and is complaining of a dull, heavy feeling in his chest.

Briefly describe what would you do and why?

c. John is diabetic and is usually placid, but over the last half-hour, he has become aggressive and volatile, and he looks as though he will lash out at one of the prison officers soon.

Briefly describe what would you do and why?

10. Are there any other comments you would wish to make about any aspect of prison health.

Section B

11. **Sex:** Female ☐

Male ☐

12. **Age:**

Please tick relevant box

Under 25 ☐

26 – 35 ☐

36 - 45 ☐

46 – 55 ☐

56 and over ☐

13. **Job title/grade:**

Please tick relevant box

Prison Officer ☐

Senior Officer ☐

Other, please state: _____

14. Length of time in prison service:

Please tick relevant box

Less than 5 years	☐
6-10 years	☐
11-15 years	☐
16-25 years	☐
26+ years	☐

15. Which of the following have you had experience of prior to joining the prison service:

Please tick relevant box(es)

University	☐
NHS	☐
Community /Social Work	☐
Armed Forces	☐
Police	☐

Other please state: _____

16. Have you received any training/education related to the health of prisoners?
Please tick relevant box

Yes	☐
No	☐

If yes, please list all prison service induction/training undertaken related to prisoners' health:

_____

_____

_____

_____

Thank you for completing this questionnaire

ISBN No. 1-840540-40-0